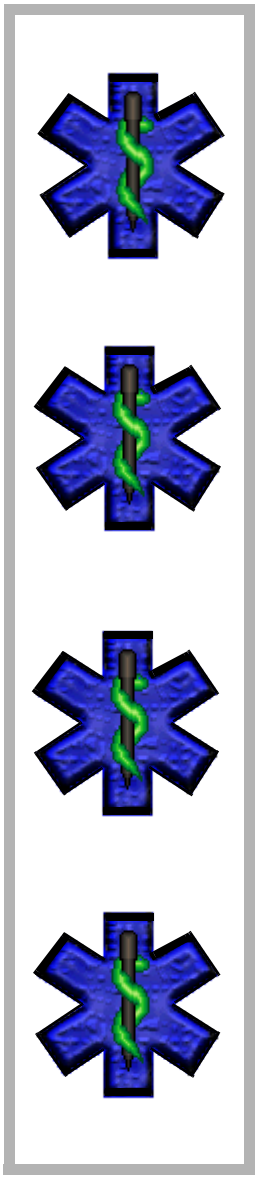

Ambulance Services

Medicaid and Other Medical Assistance Programs

MONTANA
Department of Public Health & Human Services

August 2005

This publication supersedes all previous Ambulance Services manuals. Published by the Department of Health and Human Services, January 2003.

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My Medicaid Provider ID Number:

Table of Contents

Key Contacts

Hours for Key Contacts are 8:00 a.m. to 5:00 p.m. Monday through Friday (Mountain Time), unless otherwise stated. The phone numbers designated "In state" will not work outside Montana.

Provider Enrollment

For enrollment changes or questions:

(800) 624-3958 In and out-of-state
(406) 442-1837 Helena

Send written inquiries to:

Provider Enrollment Unit
P.O. Box 4936
Helena, MT 59604

Provider Relations

For questions about eligibility, payments, denials, general claims questions, or to request provider manuals or fee schedules:

(800) 624-3958 In and out-of-state
(406) 442-1837 Helena

Send written inquiries to:

Provider Relations Unit
P.O. Box 4936
Helena, MT 59604

Claims

Send paper claims to:

Claims Processing Unit
P. O. Box 8000
Helena, MT 59604

Third Party Liability

For questions about private insurance, Medicare or other third-party liability:

(800) 624-3958 In and out-of-state
(406) 442-1837 Helena

Send written inquiries to:

ACS Third Party Liability Unit
P. O. Box 5838
Helena, MT 59604

Provider's Policy Questions

For policy questions, contact the appropriate division of the Department of Public Health and Human Services; see the *Introduction* chapter in the *General Information For Providers* manual.

Client Eligibility

For client eligibility, see the *Client Eligibility and Responsibilities* chapter in the *General Information For Providers* manual.

Authorization

Mountain-Pacific Quality Health Foundation
Medicaid Transportation
P.O. Box 6488
Helena, MT 59604

(800) 292-7114 In and out of state
(800) 291-7791 Fax
ambulance@mpqhf.org E-Mail

Direct Deposit Arrangements

Providers who would like to receive their remittance advices electronically and electronic funds transfer should call the number below.

(406) 444-5283

EDI Technical Help Desk

For questions regarding electronic claims submission:

(800) 987-6719 In and out-of-state
(406) 442-1837 Helena
(406) 442-4402 Fax

Mail to:

ACS
ATTN: MT EDI
P.O. Box 4936
Helena, MT 59604

Secretary of State

The Secretary of State's office publishes the most current version of the Administrative Rules of Montana (ARM):

(406) 444-2055 Phone

Secretary of State
P.O. Box 202801
Helena, MT 59620-2801

Key Web Sites

Web Address	Information Available
Virtual Human Services Pavilion (VHSP) vhsp.dphhs.mt.gov	**Select *Human Services* for the following information:** • **Medicaid:** Medicaid Eligibility & Payment System (MEPS). Eligibility and claims history information. • **Senior and Long Term Care:** Provider search, home/housing options, healthy living, government programs, publications, protective/legal services, financial planning. • **DPHHS:** Latest news and events, Mental Health Services Plan information, program information, office locations, divisions, resources, legal information, and links to other state and federal web sites. • **Health Policy and Services Division:** Children's Health Insurance Plan (CHIP), Medicaid provider information such as manuals, newsletters, fee schedules, and enrollment information.
Provider Information Website www.mtmedicaid.org or www.dphhs.mt.gov/hpsd/medicaid/medicaid2	• Medicaid Information • Medicaid news • Provider manuals • Notices and manual replacement pages • Fee schedules • Remittance advice notices • Forms • Provider enrollment • Frequently asked questions (FAQs) • Upcoming events • Electronic billing information • Newsletters • Key contacts • Links to other websites and more
Department of Public Health & Human Services Website http://www.dphhs.mt.gov/index.shtml	**The official DPHHS website** • Select *A-Z Index* for links to other DPHHS sites (including Medicaid)

MONTANA
Department of Public Health & Human Services

Introduction

Thank you for your willingness to serve clients of the Montana Medicaid program and other medical assistance programs administered by the Department of Public Health and Human Services.

Manual Organization

This manual provides information specifically for ambulance services providers. Each chapter has a section titled *Other Programs* that includes information about other Department programs such as the Mental Health Services Plan (MHSP) and the Children's Health Insurance Plan (CHIP). Other essential information for providers is contained in the separate *General Information For Providers* manual. Each provider is asked to review both the general manual and the specific manual for his or her provider type. Information about other non-emergency transportation services is described in the *Specialized Non-Emergency Transportation Services*, *Commercial Transportation Services*, and *Transportation Services: Mileage and Per Diem* manuals. All manuals are available from Provider Relations and on the *Provider Information* website (see *Key Contacts*).

The manual's table of contents and index allow you to quickly find answers to most questions. The margins contain important notes with extra space for writing notes. There is a list of *Key Contacts* at the beginning of each manual. We have also included a space on the back side of the front cover to record your Medicaid Provider ID number for quick reference when calling Provider Relations.

Manual Maintenance

Manuals must be kept current. Changes to manuals are provided through notices and replacement pages. When replacing a page in a manual, file the old pages in the back of the manual for use with claims that originated under the old policy. File all notices behind the tab marked "Notices."

Providers are responsible for knowing and following current laws and regulations.

Rule References

Providers must be familiar with all current rules and regulations governing the Montana Medicaid program. Provider manuals are to assist providers in billing Medicaid; they do not contain all Medicaid rules and regulations. Rule citations in the text are a reference tool; they are not a summary of the entire rule. In the event that a manual conflicts with a rule, the rule prevails. Links to rules are available on the Provider Information website (see *Key Contacts*). Paper copies of rules are available through Provider Relations and the Secretary of State's office (see *Key*

Contacts). In addition to the general Medicaid rules outlined in the *General Information For Providers* manual, the following rules and regulations are also applicable to the ambulance program:

- Code of Federal Regulations (CFR)
  - 42 CFR 431.53 Assurance of Transportation
  - 42 CFR 441.62 Transportation and Scheduling Assistance
- Administrative Rules of Montana (ARM)
  - ARM 37.86.2601 - 2605 Ambulance Services

Claims Review (MCA 53-6-111, ARM 37.85.406)

The Department is committed to paying Medicaid provider's claims as quickly as possible. Medicaid claims are electronically processed and usually are not reviewed by medical experts prior to payment to determine if the services provided were appropriately billed. Although the computerized system can detect and deny some erroneous claims, there are many erroneous claims which it cannot detect. For this reason, payment of a claim does not mean that the service was correctly billed or the payment made to the provider was correct. Periodic retrospective reviews are performed which may lead to the discovery of incorrect billing or incorrect payment. If a claim is paid and the Department later discovers that the service was incorrectly billed or paid or the claim was erroneous in some other way, the Department is required by federal regulation to recover any overpayment, regardless of whether the incorrect payment was the result of Department or provider error or other cause.

Getting Questions Answered

The provider manuals are designed to answer most questions; however, questions may arise that require a call to a specific group (such as a program officer, Provider Relations, or a prior authorization unit). The list of *Key Contacts* at the front of this manual has important phone numbers and addresses pertaining to this manual. The *Introduction* chapter in the *General Information For Providers* manual also has a list of contacts for program policy information. Medicaid manuals, notices, replacement pages, fee schedules, forms, and much more are available on the *Provider Informatio*n website (see *Key Contacts*).

MONTANA
Department of Public Health & Human Services

Covered Services

General Coverage Principles

Medicaid covers authorized ambulance transports with medical intervention by ground or air to the nearest *appropriate facility* (see *Definitions*). This chapter provides covered services information that applies specifically to ambulance services. Like all health care services received by Medicaid clients, the services, providers and clients must also meet the general requirements listed in the *General Information For Providers* manual.

Services within scope of practice (ARM 37.85.401 and 37.86.2602)

Services are covered only when provided by a licensed ambulance provider acting within the scope of the provider's license.

Vehicle requirements (ARM 37.86.2601)

An ambulance is a vehicle designed and equipped to transport a sick or injured person by ground or air. Ground ambulances can operate on water or land. Air ambulances may be either fixed wing (airplane) or rotary wing (helicopter). The ambulance must contain a stretcher, linens, first aid supplies, oxygen equipment, and other lifesaving equipment required by state or local laws. The ambulance must also be staffed by licensed or certified personnel who provide first aid treatment.

Coverage of ambulance transportation is based on the client's condition at the time of transport.

Ambulance coverage (ARM 37.86.2601 and 37.86.2602)

Ambulance services are covered when the client's medical condition requires transportation by ambulance to the nearest appropriate facility. Each service provided to the client (transport, life support, oxygen, etc.) must be medically necessary to be covered by Medicaid. All scheduled ambulance transports require prior authorization, and all non-scheduled ambulance transports require authorization before the claim is submitted. The *Authorization* chapter in this manual covers medical necessity documentation tips and how to obtain authorization. Ambulance providers must submit documentation that supports medical necessity for each service. The service is then reviewed and authorized or denied for lack of medical necessity before the claim is submitted. Once a claim is submitted, it may be denied for reasons other than medical necessity. For tips on preventing claim denials, see the *Billing Procedures* and *Completing a Claim* chapters in this manual.

The following are examples of circumstances which may be considered in determining medical necessity for ambulance service. However, the presence of any one or more of the following does not necessarily establish medical necessity.

- The client is transported in an emergency situation (e.g., as a result of an accident or injury).
- The client must be restrained for medical (not law enforcement) purposes.
- The client is unconscious or in shock.
- The client requires oxygen as an emergency rather than a maintenance measure or requires other emergency treatment on the way to the destination.
- The client has to remain immobile because of a fracture (or possible fracture) that has not been set.
- The client sustains an acute stroke or myocardial infarction.
- The client is experiencing severe bleeding, neurological dysfunction, or respiratory distress.
- The client is bed confined before and after the ambulance transport.
- The client can be moved **only** by stretcher.

Air ambulance transportation is covered when medical necessity for ambulance transport is established (refer to previous list) and one of the following conditions are met:

- When the point of pick up is inaccessible by land or water ambulance.
- When the client's condition requires emergency admission to the nearest hospital with appropriate facilities, and distance or other obstacles (e.g., traffic) prevent rapid transport.
- When air transport would be less costly to the Medicaid program.

Non-covered services (ARM 37.86.2602)

Some ambulance services that are not covered by Medicaid include the following:

- When the client can be transported by a mode other than ambulance without endangering the client's health, regardless of whether other transportation is available.
- Medicaid benefits cease at the time of death. When a client is pronounced dead after an ambulance is called but before transport, the ambulance services provided are covered at the base rate. If a client is pronounced dead by a legally authorized individual before the ambulance is called, no payment will be made.

- Medicaid will not pay ambulance providers for treatment of clients who are not transported. An example of this situation is when an ambulance is dispatched to a client's home and the client refuses to be transported. It also occurs in "paramedic intercept" calls. For example, a BLS ambulance may begin transporting a client with chest pain to a hospital some miles away. An ALS ambulance meets the basic life support (BLS) ambulance so that a paramedic can board the BLS ambulance and begin advanced life support (ALS) treatment. If the client remains on the BLS ambulance, no payment is made to the ALS ambulance provider.
- Air ambulance services are not covered to transport a client from a hospital capable of treating the client to another hospital simply because the client or family prefers a specific hospital or physician.

Importance of fee schedules

The easiest way to verify coverage for a specific service is to check the Department's fee schedule for your provider type. In addition to being listed on the fee schedule, all services provided must meet the coverage criteria listed in the *Provider Requirements* chapter of the *General Information For Providers* manual and in this chapter. Use the current fee schedule in conjunction with the more detailed coding descriptions listed in the current CPT-4 and HCPCS Level II coding books. Take care to use the fee schedule and coding books that pertain to the date of service.

Current fee schedules are available on disk, hardcopy, or on the *Provider Information* website (see *Key Contacts*). For disk or hard copy, contact Provider Relations (see *Key Contacts*).

Coverage of Specific Services

The following are coverage rules for specific ambulance services.

Air transfers

Medicaid covers air ambulance transfer of a client who is discharged from one inpatient facility and transferred and admitted to another inpatient facility when distance or urgency preclude the use of ground ambulance. If a client is an inpatient at a hospital, Medicaid does not pay separately for round trip ambulance transport for an outpatient service (e.g., x-ray or other procedure) at a different hospital. This type of transport is included in the Medicaid payment to the hospital for the inpatient stay.

All ambulance transports require authorization (see the *Authorization* chapter in this manual).

Air transport for neonates and pregnant women

Medicaid covers emergency air transport to the nearest appropriate facility for neonates (infants age 0 to 28 days) and high risk pregnant women. The neonate's inpatient hospital services must be categorized within one of the diagno-

sis related group (DRG) codes 385 through 389. The high-risk pregnant women's inpatient hospital services must be categorized within one of the DRG codes 370, 372, 375 or 383.

Although authorization for these services is not required, the provider should notify the authorizing agency within 60 days of transport (see the *Authorization* chapter in this manual). If the hospital does not meet the DRG requirements, the provider may submit the claim to Medicaid (see *Key Contacts*) as long as the provider had notified the authorizing agency within 60 days of the transport.

Ambulance non-scheduled transport

Non-scheduled ambulance services may be emergencies or they may be non-emergent transports with special circumstances that prevent scheduling. Examples include:

- Emergency transports (see *Definitions*).
- Non-emergent transports when the need became known after regular business hours.
- Meeting flight teams at airports.
- Hospital to hospital transfers to a more acute level of care.
- One-way returns to nursing homes or residences following emergency transports to an emergency room.
- Urgent transports, which may include:
    - A fall in a nursing home or community care where there is no bleeding or obvious life threatening situation, but the client should be checked for possible fracture.
    - An elderly client with flu like symptoms (possible dehydration).
    - A client who has sustained an injury and needs medical evaluation but it is not an emergency.
    - A trauma client who has been stabilized by Hospital A and must be transported to Hospital B for further treatment diagnostic tests such as a CT (computerized tomography) scan.

Not all non-emergent ambulance transports can be anticipated during regular business hours. In these cases, prior authorization is not required. However, all non-scheduled ambulance transports must be authorized before the claim is submitted (see the *Authorization* chapter in this manual).

Ambulance scheduled transport

Scheduled ambulance transports may be round trip (loop trip) or one-way. Most scheduled ambulance use is arranged during regular business hours and requires prior authorization (see the *Authorization* chapter in this manual). Examples include:

- Transport to a hospital for scheduled diagnostic tests such as CT (computerized tomography) scan or MRI (magnetic resonance imaging).
- Transport to a doctor's office or clinic for clients who can only be transported by stretcher.
- Transport to a hospital or other facility for a planned admission.
- Transfer from one acute care hospital to a lower level acute setting, as in the case of premature infants being returned from a referral hospital to a smaller hospital.
- Transport from a hospital to another setting as part of a planned discharge.

Disposable supplies

Medicaid covers disposable and non-reusable supplies such as oxygen, gauze and dressings, defibrillation supplies, and IV drug therapy disposable supplies. When medically necessary, each service is allowed one time per transport in addition to the base rate.

Drugs

Drugs are covered in addition to the base rate only when medical necessity is clearly documented.

EKG services

EKG monitoring is included in the base rate, but the technical component for obtaining tracing (no interpretation and report) is covered in addition to the base rate one time per transport.

Injectable drugs and IV solutions

Injectable drugs and IV solutions are covered in addition to the base rate when medical necessity is clearly documented.

Mileage

Although mileage is included in the base rate for ground transports, it is also paid in addition to the base rate when the pickup point is outside city limits or when transporting to another community. Mileage is only paid for loaded miles (client on board) from pickup to destination. When transporting from one community to another, if odometer readings are not shown on the trip report, then the authorizing agency will use a map program to calculate mileage.

Mileage is covered in addition to the base rate for all air transports. Air mileage is calculated for actual loaded miles flown and is expressed in statute miles.

Mileage must be medically necessary, which typically means that mileage should equal the shortest route to the nearest appropriate facility. Exceptions may occur such as road construction or weather (for air ambulance).

Multiple client transportation

When more than one client is transported during the same trip, Medicaid will cover one base rate per **client** and one mileage charge per **transport**.

Clients are not candidates for ambulance transport solely because of their oxygen requirement.

Oxygen and oxygen supplies

Medicaid covers oxygen and related disposable supplies only when the client's condition at the time of transport requires oxygen. Medicaid does not cover oxygen when it is provided only on the basis of protocol or when the client requires oxygen on a regular basis (e.g., during trips to the grocery store, etc.). The amount of oxygen provided to the client is prior authorized based on the duration of the transport and must be billed in 1/2 hour increments (see *Billing Procedures* chapter in this manual).

Transports outside Montana

Transports outside Montana are covered in most cases and require authorization.

Other Programs

The information in this chapter does not apply to the Mental Health Services Plan (MHSP) or the Children's Health Insurance Plan (CHIP). The MHSP manual is available on the Provider Information website (see *Key Contacts*). The CHIP Medical Manual is available through BlueCross BlueShield at (800) 447-7828 X8647.

MONTANA
Department of Public Health & Human Services

Authorization

Authorization

Providers must obtain prior authorization for all scheduled ambulance services and authorization within 60 days for all non-scheduled ambulance services before submitting a claim. The only exception occurs when a client has both Medicare and Medicaid. For those clients, authorization is not required for non-scheduled transport. Other authorizations that may apply to the transport (e.g., inpatient out-of-state admission authorization) do not replace the need for ambulance transport authorization.

Providers have 60 days from transport to notify the authorizing agency, six months from transport to submit paperwork, and 12 months from transport to submit a clean claim.

For authorization, contact the authorizing agency by phone, fax, or E-mail (see *Key Contacts*). The following are instructions for obtaining authorization for scheduled and non-scheduled transports. References to *trip report* refer to the medical record documented during the ambulance run, and *trip log* refers to the form in *Appendix A* that providers can use for notification purposes.

Obtaining prior authorization for scheduled transport

Prior authorization is required for all scheduled transports. The following are steps to obtain prior authorization.

1. Verify Medicaid eligibility (see the *Client Eligibility* chapter in the *General Information For Providers* manual).
2. Prepare transport documentation:
   - Name of transportation provider
   - Client's name
   - Client's Medicaid ID number
   - Point of origin to the point of destination
   - Date and time of transport
   - Reason for transport
   - Level of services to be provided during transport (e.g., BLS, ALS, mileage, oxygen, etc.)
3. Present the documentation to the authorizing agency by phone, fax, or E-mail (see *Key Contacts*) before transport.
4. The nurse reviewer will interview the requestor by phone regarding the client's medical condition and need for ambulance transport. If another mode of transport is more appropriate, the nurse reviewer will suggest alternatives. In this step of the process, it is essential to provide accurate and up-to-date medical information about the client's condition and transport requirements.

5. The nurse reviewer will give verbal authorization for qualifying transports and assign a reference number that is used in tracking the transport through the review process. This is not an authorization number.
6. Once the scheduled transport is complete, the provider mails or faxes a copy of the *trip report* and the charges to the authorizing agency with the reference number noted. This must be completed within six months of transport.
7. The authorizing agency reviews each transport to confirm that the medical record supports medical necessity for the same ambulance use which was communicated in the interview (see step 4 above). The reviewer also evaluates level of service, oxygen use, and mileage.

    - ***Approvals.*** The provider receives an approval letter with the prior authorization number. This number is also transmitted to the claims processing system, which generates a letter for the provider with notification that authorization has been received. The provider then submits the CMS-1500 claim (paper or electronic) to claims processing (see *Key Contacts*). The prior authorization number must be reported in Field 23 of the claim form (see the *Completing a Claim* chapter in this manual).
    - ***Denials.*** A scheduled ambulance transport which received verbal prior authorization from the authorizing agency may be denied if the medical record does not support the need for ambulance transport as reported to the authorizing agency before transport. If a claim is denied for medical necessity, the provider and the client are notified by letter. Providers have 30 days to appeal authorization decisions, and clients have 90 days. Appeals are directed to the authorizing agency, and instructions are given in the denial letter.

Granting of prior authorization does not guarantee payment. The claim may be denied for other reasons (see the *Billing Procedures* chapter in this manual).

Obtaining authorization for non-scheduled transport

Providers have 60 days following transport to notify the authorizing agency of non-scheduled transport. Providers may choose either of the two options to notify the authorizing agency. The following table lists the steps for obtaining authorization for non-scheduled transport.

When a client has Medicare and Medicaid, non-scheduled transports do not require authorization. Submit these claims directly to Medicare (see the *Coordination of Benefits* chapter in this manual).

Authorization for Non-Scheduled Ambulance Transport

Step	Option 1	Option 2
Step 1	Verify Medicaid eligibility (see the *Client Eligibility* chapter in the *General Information For Providers* manual)	Verify Medicaid eligibility (see the *Client Eligibility* chapter in the *General Information For Providers* manual)
Step 2	Notify the authorizing agency of the transport by submitting a copy of the *trip report** and charges (or a copy of the CMS-1500 claim form). The authorizing agency uses this information to assign a reference number and to assess medical necessity.	Notify the authorizing agency by submitting a *trip log*** (*Appendix A*).
Step 3	The authorizing agency assesses the *trip report** and assigns each qualifying transport a reference number that is used to track the transport throughout the review process. This is not an authorization number.	The authorizing agency assesses the *trip log*** and assigns each qualifying transport a reference number that is used to track the transport throughout the review process. This is not an authorization number.
Step 4	Providers then receive a *Foundation Acknowledgement Report* that contains the following information: • Itemization of the transports for which notification was received • Reference number(s) for the transport(s) that will be reviewed for authorization • Trips that will not be reviewed and the reason for non-review (e.g., Medicare cases, non-eligible clients, and transports past the 60-day notice period) The authorizing agency takes no further action on transports that did not receive reference numbers. It is the ambulance provider's responsibility to follow up on these transports.	Providers then receive a *Foundation Acknowledgement Report* that contains the following information: • Itemization of the transports for which notification was received • Reference number(s) for the transport(s) that will be reviewed for authorization • Trips that will not be reviewed and the reason for non-review (e.g., Medicare cases, non-eligible clients, and transports past the 60-day notice period) The authorizing agency takes no further action on transports that did not receive reference numbers. It is the ambulance provider's responsibility to follow up on these transports.
Step 5	Upon receipt of the reference number, the provider notes the reference number in its transport records and awaits subsequent notification from the authorizing agency of the approval or denial of the transport (see *Approvals* and *Denials* following this table). Each transport is evaluated for medical necessity, level of service, oxygen use and mileage.	Upon receipt of the reference number, the provider mails or faxes a copy of the *trip report** and charges (or a completed CMS-1500 claim form) to the authorizing agency. Include the reference number in Field 23 of the claim form. This paperwork must be submitted within six months from the transport date.
Step 6		Provider awaits notification from the authorizing agency of the approval or denial of the transport. The authorizing agency evaluates each transport for medical necessity, level of service, oxygen use and mileage, and then it is approved or denied (see *Approvals* and *Denials* following this table).

**Trip report* refer to the medical record documented during the ambulance run.
***Trip log* refers to the form in *Appendix A* that providers can use for notification purposes.

Approvals

The provider will receive an approval letter with the prior authorization number. This number is also transmitted to the claims processing system, which generates a letter for the provider with notification that authorization has been received. The provider then submits the CMS-1500 claim (paper or electronic) to claims processing (see *Key Contacts*). Include the prior authorization number in Field 23 of the claim form (see the *Completing a Claim* chapter in this manual).

Denials

If a claim is denied for medical necessity, the provider and the client will be notified by letter. Providers have 30 days to appeal authorization decisions, and clients have 90 days.

Time Requirements

Providers have 60 days from a non-scheduled transport to notify the authorizing agency, six months from transport to submit paperwork for authorization, and 12 months from transport to submit a clean claim (see the *Billing Procedures* chapter in this manual). The Department will not consider claims that have not been authorized or that are past any of these time limits, even if another payer is involved (see the *Coordination of Benefits* chapter in this manual). The following table shows an example.

Time Requirements Example for Non-Scheduled Transports

Requirement	Deadline
Non-scheduled transport provided	August 1, 2002
60 days to notify the authorizing agency of transport	September 30, 2002
Six months to submit paperwork for authorization	February 1, 2002
Twelve months to submit a clean claim to Medicaid	August 1, 2003

Retroactive Eligibility

When a client has retroactive Medicaid eligibility, the provider must notify the authorizing agency of transport within 90 days of the eligibility determination date. See the *General Information For Providers*, *Client Eligibility* chapter for more information on retroactive eligibility.

Tips for Establishing Medical Necessity

- Coverage of ambulance transportation is based on the client's condition at the time of transport.
- Medical necessity must be demonstrated in the *trip report*. If documentation is not clear and complete, the transport will be denied for lack of medical necessity.
- The ambulance provider is responsible for making sure medical necessity is both valid and well documented. Providers must state objective findings such as respiratory rate 32 with diaphoresis, etc. These details are necessary to establish medical necessity for the transport.
- A doctor's or a hospital's order for ambulance transportation is not sufficient to guarantee that Medicaid will pay for the transport.
- A note "stretcher patient" or "patient was moved by stretcher" does not indicate that the client could only be moved by stretcher.

PASSPORT to Health

PASSPORT to Health is Montana Medicaid's Primary Care Case Management (PCCM) Program and has been very successful since implementation in 1993. Under PASSPORT, Medicaid clients choose one primary care provider and develop an ongoing relationship that provides a "medical home." With some exceptions, all services to PASSPORT clients must be provided or approved by the PASSPORT provider. Ambulance services do not require approval by a client's PASSPORT Provider. The PASSPORT mission is to manage the delivery of health care to Montana Medicaid clients in order to improve or maintain access and quality while minimizing use of health care resources. Approximately 68% of the Medicaid population is enrolled in PASSPORT. All Montana Medicaid clients must participate in PASSPORT except for nursing homes and institution residents, clients with Medicare coverage, medically needy clients with incurments, or clients living in non-PASSPORT counties. Any Montana Medicaid provider may be a PASSPORT provider if primary care is within his or her scope of practice. The PASSPORT Program saves the Medicaid program approximately $20 million each year. These savings allow improved benefits elsewhere in the Medicaid program.

Other Programs

The information in this chapter does not apply to the Mental Health Services Plan (MHSP) or the Children's Health Insurance Plan (CHIP). The MHSP manual is available on the Provider Information website (see *Key Contacts*). The CHIP Medical Manual is available through BlueCross BlueShield at (800) 447-7828 X8647.

Coordination of Benefits

When Clients Have Other Coverage

Medicaid clients often have coverage through Medicare, workers' compensation, employment-based coverage, individually purchased coverage, etc. Coordination of benefits is the process of determining which source of coverage is the primary payer in a particular situation. In general, providers must bill other carriers before billing Medicaid, but there are some exceptions (see *Exceptions to Billing Third Party First* later in this chapter). Medicare coverage is processed differently than other sources of coverage.

Identifying Other Sources of Coverage

The client's Medicaid ID card may list other payers such as Medicare or other third party payers (see *Client Eligibility and Responsibilities* in the *General Information For Providers* manual). If a client has Medicare, the Medicare ID number is listed on the card. If a client has other coverage (excluding Medicare), it will be shown under the "TPL" section of the ID card. Some examples of third party payers include:

- Private health insurance
- Employment-related health insurance
- Workers' compensation insurance*
- Health insurance from an absent parent
- Automobile insurance*
- Court judgments and settlements*
- Long term care insurance

*These third party payers (and others) may **not** be listed on the client's ID card.

Medicare claims are processed differently than other sources of coverage.

Providers must use the same procedures for locating third party sources for Medicaid clients as for their non-Medicaid clients. Providers cannot refuse service because of a third party payer or potential third party payer.

When a Client Has Medicare

Medicare claims are processed and paid differently than claims involving other payers. The other sources of coverage are referred to as "third party liability" (TPL), but Medicare is not.

Medicare Part A claims

Medicare Part A covers inpatient hospital care, skilled nursing care and other services. Medicare Part A services are covered in more detail in specific program manuals where the providers bill for Part A services.

Medicare Part B crossover claims

Medicare Part B covers ambulance transports, physician care, and other services. The Department has an agreement with Medicare Part B carriers for Montana (BlueCross BlueShield of Montana and the Durable Medical Equipment Regional Carrier [DMERC]). Under this agreement, the carriers provide the Department with a magnetic tape of CMS-1500 (formerly HCFA-1500) claims for clients who have both Medicare and Medicaid coverage. In order to have claims automatically cross over from Medicare to Medicaid, the provider must:

- Accept Medicare assignment (otherwise payment and the Explanation of Medicare Benefits (EOMB) go directly to the client and will not crossover).
- Submit their Medicare and Medicaid provider numbers to Provider Relations (see *Key Contacts*).

To avoid confusion and paperwork, submit Medicare Part B crossover claims to Medicaid only when necessary.

In these situations, ambulance providers need not submit Medicare Part B crossover claims to Medicaid. Medicare will process the claim, submit it to Medicaid, and send the provider an EOMB. Providers must check the EOMB for the statement indicating that the claim has been referred to Medicaid for further processing. It is the provider's responsibility to follow up on crossover claims and make sure they are correctly billed to Medicaid within the timely filing limit (see *Billing Procedures*).

When Medicare pays or denies a service

- When Medicare pays a claim (scheduled or non-scheduled transport) for a provider that is set up for automatic crossover, the claim should automatically cross over to Medicaid for processing, so the provider does not need to submit it to Medicaid.

  Providers that are not set up for automatic crossover should submit a claim (paper or electronic) to Medicaid after Medicare pays, and it will be considered for coinsurance and deductible (see *Submitting Medicare claims to Medicaid* later in this chapter). When Medicare pays for a non-scheduled transport, a prior authorization number is not required when billing Medicaid.
- When Medicare denies a non-scheduled transport claim as not medically necessary, Medicaid will also deny the claim as not medically necessary. Appeals must be directed to Medicare.

For details on how Medicaid calculates payment for Medicare claims, see the *How Payment Is Calculated* chapter in this manual.

- When Medicare denies a non-scheduled transport for a reason other than lack of medical necessity, providers must appeal the denial to Medicare. If the Medicare denial is upheld at appeal, send the claim, trip report, and Medicare denial (with explanation of denial codes), and documentation of appeal outcome to the authorizing agency (see *Key Contacts*) for consideration.

All Part B Crossover claims submitted to Medicaid before Medicare's 45-day response time will be returned to the provider.

When Medicaid does not respond to crossover claims

When Medicaid does not respond within 45 days of the provider receiving the Medicare EOMB, submit a paper CMS-1500 (formerly HCFA-1500) claim form, with a copy of the Medicare EOMB attached, to Medicaid for processing.

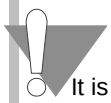
Remember to submit Medicare crossover claims to Medicaid only:

- When the "referral to Medicaid" statement is missing from the provider's EOMB.
- When the provider does not hear from Medicaid within 45 days of receiving the Medicare EOMB.
- When Medicare denies the claim.

Submitting Medicare claims to Medicaid

When submitting a paper claim to Medicaid, attach the Medicare EOMB and use Medicaid billing instructions and codes. Medicare's instructions, codes, and modifiers may not be the same as Medicaid's. The claim must also include the Medicaid provider number and Medicaid client ID number.

When a Client Has TPL (ARM 37.85.407)



It is the provider's responsibility to follow up on TPL claims and make sure they are billed correctly to Medicaid within the 12-month timely filing period.

When a Medicaid client has additional medical coverage (other than Medicare), it is often referred to as third party liability or TPL. In most cases, providers must bill other insurance carriers before billing Medicaid. Keep in mind that Medicaid will not consider a claim unless the provider has obtained prior authorization for scheduled transport and authorization for non-scheduled transports from the authorizing agency (see the *Authorization* chapter in this manual). Providers have 60 days from transport to notify the authorizing agency of transport, six months from transport to submit paperwork for authorization, and 12 months from transport to submit a clean claim to Medicaid, even when another payer is involved (see the *Authorization* chapter in this manual).

Providers are required to notify their clients that any funds the client receives from third party payers (when the services were billed to Medicaid) must be turned over to the Department. The following words printed on the client's statement will fulfill this requirement: "When services are covered by Medicaid and another source, any payment the client receives from the other source must be turned over to Medicaid."

Exceptions to billing third party first

In a few cases, providers may bill Medicaid first.

- When a Medicaid client is also covered by Indian Health Service (IHS) or the Montana Crime Victim's Compensation Fund, providers must bill Medicaid before IHS or Crime Victim's. These are not considered third party liability.
- If the third party has only potential liability, such as automobile insurance, the provider may bill Medicaid first. Do not indicate the potential third party on the claim form. Instead, notify the Department of the potential third party by sending the claim and a note to the Department Third Party Liability Unit:

  Third Party Liability Unit
  Department of Public Health & Human Services
  P.O. Box 202953
  Helena, MT 59620-2953

Requesting an exemption

Providers may request to bill Medicaid first under certain circumstances. In each of these cases, the claim and required information must be sent directly to the ACS Third Party Liability Unit (see *Key Contacts*).

- When a provider is unable to obtain a valid *assignment of benefits* (see *Definitions*), the provider must submit the claim form with documentation that the provider attempted to obtain assignment and certification that the attempt was unsuccessful.
- When the child support enforcement division has required an absent parent to have insurance on a child, the claim can be submitted to Medicaid when the following requirements are met:
  1. The third party carrier has been billed, and 30 days or more have passed since the date of service.
  2. The claim is accompanied by a certification that the claim was billed to the third party carrier, and payment or denial has not been received.
- If another insurance has been billed, and 90 days have passed with no response, attach a note to the claim explaining that the insurance company has been billed (or attach a copy of the letter sent to the insurance company). Include the date the claim was submitted to the insurance company and certification that there has been no response.
- When the provider has billed the third party insurance and has received a non-specific denial (e.g., no client name, date of service, amount billed), submit the claim with a copy of the denial and a letter of explanation directly to Medicaid in order to avoid missing the timely filing deadline.

When the third party pays or denies a service

When a third party payer is involved (excluding Medicare) and the other payer:

- Pays the claim, indicate the amount paid in the "amount paid" field of the claim when submitting to Medicaid for processing. These claims may be submitted either electronically or on paper.
- Allows the claim, and the allowed amount went toward client's deductible, include the insurance Explanation of Benefits (EOB) when billing Medicaid. These claims must be submitted on paper.
- Denies the claim, include a copy of the denial (including the reason and the reason explanation) with the claim form, and submit to Medicaid on paper.
- Denies a line on the claim, bill the denied lines together on a separate claim form and submit to Medicaid. Include the explanation of benefits (EOB) from the other payer as well as an explanation of the reason for denial (e.g., definition of denial codes).

If the provider receives a payment from a third party after the Department has paid the provider, the provider must return the lower of the two payments to the Department within 60 days.

When the third party does not respond

If another insurance has been billed, and 90 days have passed with no response, bill Medicaid as follows:

- Attach to the claim a note explaining that the insurance company has been billed (or attach a copy of the letter sent to the insurance company).
- Include the date the claim was submitted to the insurance company.
- Send this information to the ACS Third Party Liability Unit (see *Key Contacts*).

For details on how Medicaid calculates payment for TPL claims, see the *How Payment Is Calculated* chapter in this manual.

Other Programs

The information in this chapter does not apply to the Mental Health Services Plan (MHSP) or the Children's Health Insurance Plan (CHIP). The MHSP manual is available on the Provider Information website (see *Key Contacts*). The CHIP Medical Manual is available through BlueCross BlueShield at (800) 447-7828 X8647.

Billing Procedures

Claim Forms

Services provided by the health care professionals covered in this manual must be billed to Medicaid either electronically or on a CMS-1500 claim form (formerly known as the HCFA-1500). CMS-1500 forms are available from various publishing companies; they are not available from the Department, the authorizing agency, or Provider Relations.

Timely Filing Limits (ARM 37.85.406)

Providers must submit clean claims to Medicaid within the latest of:

- Twelve months from whichever is later:
  - the date of service
  - the date retroactive eligibility or disability is determined
- ***Medicare crossover claims:*** Six months from the date on the Medicare explanation of benefits approving the service (if the Medicare claim was timely filed and the client was eligible for Medicare at the time the Medicare claim was filed).
- ***Claims involving other third party payers (excluding Medicare):*** Six months from the date on an adjustment notice from a third party payer who has previously processed the claim for the same service, and the adjustment notice is dated after the periods described above.

It is the provider's responsibility to follow up with all claims and make sure all problems are resolved within the twelve-month timely filing limit.

Clean claims are claims that can be processed without additional information or action from the provider. The submission date is defined as the date that the claim was received by the Department or the claims processing contractor. All errors and problems with claims must be resolved within this 12 month period.

Tips to avoid timely filing denials

- Correct and resubmit denied claims promptly (see the *Remittance Advices and Adjustments* chapter in this manual).
- If a claim submitted to Medicaid does not appear on the remittance advice within 30 days, contact Provider Relations for claim status (see *Key Contacts*).
- If another insurer has been billed and 90 days have passed with no response, you can bill Medicaid (see the *Coordination of Benefits* chapter in this manual for more information).
- To meet timely filing requirements for Medicare/Medicaid crossover claims, see the *Coordination of Benefits* chapter in this manual.

When To Bill Medicaid Clients (ARM 37.85.406)

When services are not covered by Medicaid, providers may bill clients directly. For example, an ambulance service may bill a client for care provided at the client's home if the client declines to be transported.

In most circumstances, providers may not bill Medicaid clients for services covered under Medicaid. The main exception is when a service is denied by both Medicare and Medicaid as not medically necessary. In this case, the provider can bill the client for the service without prior notification. The client may also be billed if a claim is denied because the client is not enrolled in Medicaid.

If a provider bills Medicaid and the claim is denied because the client is not eligible, the provider may bill the client directly.

More specifically, providers cannot bill clients directly:

- For the difference between charges and the amount Medicaid paid.
- When the provider bills Medicaid for a covered service, and Medicaid denies the claim because of billing errors.
- When a provider fails to obtain authorization before a scheduled transport or within 60 days following a non-scheduled transport.
- When a third-party payer does not respond (see the *Coordination of Benefits* chapter in this manual).

Note that there is a critical difference between situations where Medicaid does not cover the service and situations where Medicaid covers the service but the Medicaid payment is less than the provider's charge. When Medicaid covers the service, providers must accept Medicaid rates (including any Medicaid cost sharing amounts payable by the client) as payment in full.

Usual and Customary Charge (ARM 37.85.406 and 37.86.2605)

Providers should bill Medicaid their usual and customary charge for each service; that is, the same charge that is made to other payers for that service.

When Clients Have Other Insurance

If a Medicaid client is also covered by Medicare, has other insurance, or some other third party is responsible for the cost of the client's health care, see the *Coordination of Benefits* chapter in this manual.

Billing for Retroactively Eligible Clients

When a client becomes retroactively eligible for Medicaid, the provider has 90 days from the date retroactive eligibility was determined to obtain authorization for transport, and 12 months from the eligibility determination date to submit a clean claim for those services (see the *Authorization* and *Billing Procedures* chap-

ters in this manual). When submitting claims for retroactively eligible clients, attach a copy of the FA-455 (eligibility determination letter) to the claim if the date of service is more than 12 months earlier than the date the claim is submitted. For more information on retroactive eligibility, see the *Client Eligibility and Responsibilities* chapter in the *General Information For Providers* manual.

Place of Service

Place of service must be entered correctly on each line. See *Appendix C* for place of service codes.

Coding

Standard use of medical coding conventions is required when billing Medicaid. With the exception of some local codes, Provider Relations or the Department cannot suggest specific codes to be used in billing for services. For coding assistance and resources, see the following table of *Coding Resources*. These suggestions may help reduce coding errors and unnecessary claim denials:

- Use current CPT-4, HCPCS Level II, and ICD-9-CM coding books.
- Always read the complete description and guidelines in the coding books. Relying on short descriptions can result in inappropriate billing.
- Attend classes on coding offered by certified coding specialists.
- Bill for the appropriate level of service provided. The *Covered Services* chapter in this manual contains guidelines for the different levels of life support.
- Use the correct "units" measurement on CMS-1500 claims. In general, Medicaid follows the definitions in the CPT-4 and HCPCS Level II billing manuals. Unless otherwise specified, one unit equals one transport, one procedure, or one statute mile. For specific codes, however, one unit may be 30 minutes, a percentage of body surface area, or another quantity. Always check the long text of the code description.

Always refer to the long descriptions in coding books.

Coding Resources

Please note that the Department does not endorse the products of any particular publisher.

Resource	Description	Contact
ICD-9-CM	• ICD-9-CM diagnosis and procedure codes definitions • Updated each October.	Available through various publishers and bookstores
CPT-4	• CPT-4 codes and definitions • Updated each January	American Medical Association (800) 621-8335 www.amapress.com or Medicode (Ingenix) (800) 765-6588 www.medicode.com or www.ingenixonline.com
HCPCS Level II	• HCPCS Level II codes and definitions • Updated each January and throughout the year	Available through various publishers and bookstores or from CMS at www.cms.gov/medicare/hcpcs
CPT Assistant	A newsletter on CPT-4 coding issues	American Medical Association (800) 621-8335 www.amapress.com
Miscellaneous resources	Various newsletters and other coding resources.	Medicode (Ingenix) (800) 765-6588 www.medicode.com or www.ingenixonline.com
CCI Policy and Edits Manual	This manual contains Correct Coding Initiative (CCI) policy and edits, which are pairs of CPT-4 or HCPCS Level II codes that are not separately payable except under certain circumstances. The edits are applied to services billed by the same provider for the same client on the same date of service.	National Technical Information Service (800) 363-2068 (703) 605-6060 www.ntis.gov/product/correct-coding.htm

Providers have 60 days from transport to notify the authorization agency, six months from transport to submit paperwork, and 12 months from transport to submit a clean claim.

Using the Medicaid Fee Schedule

When billing Medicaid, it is important to use the Department's fee schedule for ambulance providers in conjunction with the detailed coding descriptions listed in the current CPT-4 and HCPCS Level II coding books. In addition to covered services and payment rates, fee schedules often contain helpful information such as authorization requirements and other information. Department fee schedules are usually updated each January and July. Current fee schedules are available on the *Provider Information* website (see *Key Contacts*). For disk or hardcopy, contact Provider Relations (see *Key Contacts*).

Using Modifiers

Origin/destination modifiers are recommended when billing Medicaid but are not required (see following table *Origin/Destination Modifiers*). Modifiers can help clarify transport information. The following are some tips for using modifiers.

- Review the guidelines for using modifiers in the most current CPT-4, HCPCS Level II, or other helpful resources.
- Always read the complete description for each modifier; some modifiers are described in the CPT-4 manual while others are in the HCPCS Level II book.

Origin/Destination Modifiers

Modifier	Description
D	Diagnostic or therapeutic site other than "P" or "H" when these codes are used as origin codes.
E	Residential, domiciliary, custodial facility (other than an 1819 facility)
G	Hospital-based dialysis facility (hospital or hospital-related)
H	Hospital
I	Site of transfer (e.g., airport or helicopter pad) between types of ambulance
J	Non hospital-based dialysis facility
N	Skilled nursing facility (SNF) (1819 facility)
P	Physician's office (includes HMO non-hospital facility, clinic, etc.)
R	Residence
S	Scene of accident or acute event
X	(Destination code only) intermediate stop at physician's office on the way to the hospital (includes HMO non-hospital facility, clinic, etc.)

Billing Tips for Specific Services

Before billing Medicaid, all ambulance services must be authorized (see the *Authorization* chapter in this manual). The CMS-1500 claim form must contain a valid Montana Medicaid procedure code, a valid ICD-9-CM diagnosis code, and an authorization code (see the *Completing a Claim* and *Authorization* chapters in this manual). A complete list of Montana Medicaid procedure codes for ambulance services is available on the Ambulance fee schedule which you may request from Provider Relations or download from the Provider Information website (see *Key Contacts*). The proper diagnosis code for the client being served can be obtained from the client's physician.

Air transfers

When billing Medicaid, use the appropriate life support code and mileage for either fixed or rotary wing aircraft. Medicaid will only pay for mileage to the nearest appropriate facility.

Air transport for neonates and pregnant women

Hospital flight teams may bill Medicaid for these transports on a UB-92 claim form and receive hospital outpatient payment (refer to the *Hospital Services Outpatient* manual). If the transport does not group to a qualifying DRG, the provider may bill Medicaid on a CMS-1500 claim form as long as all Medicaid authorization requirements have been met (see the *Authorization* chapter in this manual).

Ambulance scheduled transport

When a client is transported to a scheduled service and returned to the point of origin on the same day, it is considered a "loop trip." Loop trips within a 10-mile radius of the provider's base are billed to Medicaid as one Basic Life Support (BLS) base rate (refer to the ambulance fee schedule). Loop trips beyond the 10-mile radius of the provider's base may be billed as two (BLS) base rates. Providers may bill for mileage in addition to the base rates when applicable (see the *Covered Services* chapter in this manual). For example, an ambulance transports an outpatient from a hospital in Wolf Point to Glasgow and back for a CT (computerized axial tomographic) scan. This is considered a scheduled loop trip to a neighboring community 45 miles away (98 round trip) and would be billed like this:

24. A						B	C	D	E	F	G	H	I	J	K
DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	DIAGNOSIS CODE	$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE
1 08	12	02	08	12	02	41	01	A0428		1	441 40	2				
2 08	12	02	08	12	02	41	01	A0425		1	388 08	98				

Base rates

Providers must bill using the following definitions, which are intended to be very similar to Medicare definitions. In case of difference, however, the Medicaid definition prevails. Providers should check the ambulance fee schedule for codes that correspond with the definitions below.

In the following definitions, "emergency transport" refers to the level of service required to respond to an emergency call. It does not require the use of lights and siren during the actual transport to the hospital. For example, a response to a chest pain call, whether it came in through 911 or to the ambulance service itself, would be an emergency transport, even if the client's condition after assessment did not require the use of lights and siren during transport. A response to a request to transfer a client home from the hospital, even if it came through 911, would not be an emergency response.

- ***Basic life support (BLS).*** This level of service is transportation by ground ambulance and provision of medically necessary supplies and BLS service. The ambulance and its crew must meet Montana standards for BLS care (or the equivalent in another state, if a Medicaid client requires ambulance transport outside Montana).

  Provision of care by an EMT-intermediate or paramedic does not turn a BLS call into ALS.

- ***Basic life support - emergency (BLS - emergency).*** This is the same BLS (above) but in emergency circumstances.

  Provision of care by an EMT-intermediate or paramedic does not turn a BLS call into ALS. For example, the transport of a football player with an isolated ankle fracture would be a BLS call even if a paramedic assessed the client.

- ***Advanced life support level 1 (ALS1).*** This level of service is transportation by ground ambulance and provision of medically necessary supplies and at least one ALS intervention. The ambulance and its crew must meet Montana standards for ALS care (or the equivalent in another state, if a Medicaid client requires ambulance transport outside Montana). An ALS intervention refers to the provision of care outside the scope of an EMT-basic and must be medically necessary (e.g., medically necessary EKG monitoring, drug administration). An ALS assessment does not necessarily result in a determination that the client requires an ALS level of service.
- ***Advanced life support level 1 - emergency (ALS1 - emergency).*** This is the same as ALS1 except in emergency circumstances.
- ***Advanced life support level 2 (ALS2).*** This level of care requires one of the following:
    - At least three separate administrations of one or more different medications by intravenous push/bolus or by continuous infusion (excluding crystalloid fluids). The use of three separate administrations must be medically necessary and appropriate; an example would be three doses of 1 mg epinephrine to a client in ventricular fibrillation. Splitting doses (e.g., giving the client 0.4 mg, 0.3 mg and 0.3 mg IV) to meet the definition for this level of care would be inappropriate. Crystalloid fluids include normal saline, D5W and Lactated Ringer's. A continuous infusion of dopamine, lidocaine or another drug, on the other hand, would count as one of the three separate administrations.
    - Provision of at least one of the following procedures:
        - Manual defibrillation/cardioversion (not merely EKG monitoring)
        - Endotracheal intubation (which includes monitoring an ET tube inserted before transport)
        - Central venous line
        - Cardiac pacing
        - Chest decompression
        - Surgical airway
        - Intraosseous line

      This level of care need not be provided under emergency circumstances, though in practice that would be most common.
- ***Specialty care transport (SCT).*** This level of service refers to hospital-to-hospital transportation of a critically injured or ill client by ground ambulance, including the provision of medically necessary supplies and services, at a level of service beyond the scope of a paramedic. SCT is necessary when a client's condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area. Examples are emergency or critical care nursing, emer-

gency medicine, respiratory care, cardiovascular care or a paramedic with additional training (as recognized by the State).

- ***Fixed wing air transport.*** This level of service is one-way transport by air ambulance, regardless of whether BLS or ALS care is provided.
- ***Rotary wing transport.*** This level of service is one-way transport by helicopter, regardless of whether BLS or ALS care is provided.

Mileage

Providers may bill for client-loaded miles using a mileage code shown in the fee schedule only if one of the following circumstances applies:

- A ground ambulance picks up a client outside the limits of the city in which the ambulance is based.
- A ground ambulance transports a client between communities.
- The transport is by fixed wing or rotary wing air ambulance.

When billing for mileage, one unit is equal to one statute mile for both air and ground transport. Mileage must be rounded to the nearest mile.

If the transport is outside Montana, use the appropriate code from the fee schedule. Contact the authorizing agency for details (see *Key Contacts*).

Multiple client transportation

When more than one client is transported during the same transport, providers may bill Medicaid for one base rate per client but only one mileage charge per transport.

Oxygen

When billing Medicaid for oxygen, one unit is equal to a half hour of oxygen usage. For example, if the authorizing agency approves oxygen for a one hour transport, it would be billed like this:

24. A						B	C	D	E	F		G	H	I	J	K
DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	DIAGNOSIS CODE	$ CHARGES		DAYS OR UNITS	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE
1 10	01	02	10	01	02	41	01	A0422		1	32	00	2				

Separately billable services and supplies

Providers may bill for these services and supplies using applicable codes in the fee schedule. Each of these codes is billable only once per transport.

Submitting a Claim

Paper claims

Unless otherwise stated, all paper claims must be mailed to:

Claims Processing
P.O. Box 8000
Helena, MT 59604

Electronic claims

Providers who submit claims electronically experience fewer errors and quicker payment. Claims may be submitted electronically by the following methods:

- ACS field software (available from Provider Relations)
- A claims clearinghouse
- By writing your own software using NSF 3 Montana Medicaid specifications

For more information on electronic claims submission, call the Electronic Data Interchange (EDI) Technical Help Desk (see *Key Contacts*).

The information on electronic claims submission will change with the implementation of the electronic transaction standards under the Health Insurance Portability and Accountability Act (HIPAA) in October, 2003. Providers will be notified of changes in the *Montana Medicaid Claim Jumper* newsletter.

Claim Inquiries

Contact Provider Relations for questions regarding client eligibility, payments, denials, general claim questions, or to request billing instructions, manuals, or fee schedules (see *Key Contacts*).

If you prefer to communicate with Provider Relations in writing, use the *Montana Medicaid Claim Inquiry* form in *Appendix B*. Complete the provider information at the top, and the claim information for up to three claims, and mail or fax to Provider Relations.

Provider Relations will respond to the inquiry within 7 to 10 days. The response will include the status of the claim: paid (date paid), denied (date denied), or in process. Denied claims will include an explanation of the denial and steps to follow for payment (if the claim is payable).

The Most Common Billing Errors and How to Avoid Them

Paper claims are often returned to the provider before they can be processed, and many other claims (both paper and electronic) are denied. To avoid unnecessary returns and denials, double check each claim to confirm the following items are included and accurate.

Common Billing Errors

Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Medicaid provider number missing or invalid	The provider number is a 7-digit number assigned to the provider during Medicaid enrollment. Verify the correct **Medicaid** provider number is on the claim.
Authorized signature missing	Each claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be typed, stamped, or hand-written.
Signature date missing	Each claim must have a signature date.
Incorrect claim form used	The claim must be the correct form for the provider type. Services covered in this manual require a CMS-1500 claim form, except for air transports for neonates and pregnant women, which is submitted on a UB-92 form (see *Air transports for neonates and pregnant women* earlier in this chapter).
Information on claim form not legible	Information on the claim form must be legible. Use dark ink and center the information in the field. Information must not be obscured by lines.
Recipient number not on file, or recipient was not eligible on date of service	Before providing services to the client: • View the client's ID card. Medicaid eligibility may change monthly. • Verify client eligibility by using one of the methods described in the *Client Eligibility and Responsibilities* chapter of the *General Information For Providers* manual.
Duplicate claim	• Please check all remittance advices (RAs) for previously submitted claims before resubmitting. • When making changes to previously paid claims, submit an adjustment form rather than a new claim form (see *Remittance Advices and Adjustments* in this manual). • Please allow 45 days for the Medicare/Medicaid Part B crossover claim to appear on the RA before submitting the claim directly to Medicaid.
Prior authorization number is missing	• Authorization is required for all transports (except Medicare crossover claims for non-scheduled transports). The authorization number must be on the claim form (see the *Authorization* chapter in this manual).
TPL on file and no credit amount on claim	• If the client has other insurance (or Medicare), bill the other carrier before Medicaid. See *Coordination of Benefits* in this manual. • If the client's TPL coverage has changed, providers must notify the TPL unit (see *Key Contacts*) before submitting a claim.

Common Billing Errors (continued)

Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Claim past 365-day filing limit	• The Claims Processing Unit must receive all clean claims and adjustments within the timely filing limits described in this chapter. • To ensure timely processing, claims and adjustments must be mailed to Claims Processing at the address shown in *Key Contacts*.
Missing Medicare EOMB	All paper Medicare crossover claims must have an Explanation of Medicare Benefits (EOMB) attached, and be billed to Medicaid on paper.
Provider is not eligible during dates of services, or provider number terminated	• Out-of-state providers must update enrollment early to avoid denials. If enrollment has lapsed, claims submitted with a date of service after the expiration date will be denied until the provider updates his or her enrollment. • New providers cannot bill for services provided before Medicaid enrollment begins. • If a provider is terminated from the Medicaid program, claims submitted with a date of service after the termination date will be denied.
Type of service/procedure is not allowed for provider type	• Provider is not allowed to perform the service, or type of service is invalid. • Verify the procedure code is correct using current HCPCS and CPT-4 billing manual. • Check the Medicaid fee schedule to verify the procedure code is valid for your provider type.

Other Programs

The information in this chapter does not apply to the Mental Health Services Plan (MHSP) or the Children's Health Insurance Plan (CHIP). The MHSP manual is available on the Provider Information website (see *Key Contacts*). The CHIP Medical Manual is available through BlueCross BlueShield at (800) 447-7828 X8647.

MONTANA
Department of Public Health & Human Services

Completing a Claim Form

The services described in this manual are billed on CMS-1500 claim forms. Claims submitted with all of the necessary information are referred to as "clean" and are usually paid in a timely manner (see the *Billing Procedure*s chapter in this manual).

Claims are completed differently for the different types of coverage a client has. This chapter includes instructions and a sample claim for each of the following scenarios:

- Client has Medicaid coverage only
- Client has Medicaid and Medicare coverage
- Client has Medicaid and third party liability coverage
- Client has Medicaid, Medicare, and third party liability coverage
- Client has Medicaid, Medicare, and Medicare supplement coverage

When completing a claim, remember the following:

- Required fields are indicated by "*".
- Fields that are required if the information is applicable to the situation or client are indicated by "**".
- Field 24h, *EPSDT/family planning*, is used as an indicator for cost sharing and PASSPORT authorization requirements for certain clients or services. The following are accepted codes:

EPSDT/Family Planning Indicators

Code	Client/Service	Purpose
1	EPSDT	This indicator is used when the client is under age 21
2	Family planning	This indicator is used when there is Medicaid cost sharing and PASSPORT authorization on the line
3	EPSDT and family planning	This indicator is used for Medicaid cost sharing and PASS-PORT authorization for persons under the age of 21
4	Pregnancy (any service provided to a pregnant woman)	This indicator is used when there is Medicaid cost sharing on the claim
6	Nursing facility client	This indicator is used when there is Medicare edit for oxygen services on the line

- Unless otherwise stated, all paper claims must be mailed to the following address:

  Claims Processing Unit
  P.O. Box 8000
  Helena, MT 59604

Client Has Medicaid Coverage Only

Field #	Field Title	Instructions
1	Program	Check Medicaid.
1a	Insured's ID number	Leave this field blank for Medicaid only claims.
2*	Patient's name	Enter the client's name as it appears on the Medicaid ID card.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check male or female box.
5	Patient's address	Client's address and telephone number.
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. If you answered "yes" to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on their ID card.
11d*	Is there another health benefit plan?	Enter "No". If "Yes", follow claim instructions for appropriate coverage later in this chapter.
14	Date of current illness, injury, pregnancy	Enter date in month/day/year format. This field is optional for Medicaid only claims.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year format. This field is optional for Medicaid only claims.
17	Name of referring physician	Enter the name of the referring physician. For PASSPORT clients, the name of the client's PASSPORT provider goes here.
17a	ID number of referring physician	Enter the referring or ordering physician's Medicaid ID number. For PASSPORT clients, enter the client's PASSPORT provider's PASSPORT ID number (UPIN).
18	Hospitalization dates related to current service	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization. This field is optional for Medicaid only claims.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No". Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
23*	Prior authorization number	Enter the authorization number assigned by the authorizing agency (not the tracking number).
24a*	Date(s) of service	Enter date(s) of service for each procedure, service, or supply.
24b*	Place of service	Enter the appropriate two-digit place of service (see *Appendix C*).
24c*	Type of service	Enter Montana's type of service code: Nursing facilities are "9", and all others are "0" (zero).
24d*	Procedure, service, or supplies	Enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter the appropriate CPT-4/HCPCS modifier. Medicaid recognizes two pricing and one informational modifier per code.
24e*	Diagnosis code	Enter the corresponding diagnosis code **reference number** (1, 2, 3 or 4) from field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.
24f*	Charges	Enter your reasonable and customary charges (or the Department-designated charges) for the procedure(s) on this line.
24g*	Days or units	Enter the number of units or days for the procedure and date(s) of service billed on this line (see *Billing Procedures*, *Coding* for additional tips on days/units). Anesthesia providers must bill using minutes.
24h**	EPSDT/family planning	If applicable, enter the appropriate code for the client/service: 1, 2, 3, 4, 5 or 6 (see complete description in the *EPSDT/Family Planning Indicators* table earlier in this chapter).
24i*	EMG (Emergency)	Enter an "X" if this service was rendered in a hospital emergency room to override Medicaid copay.
28*	Total charge	Enter the sum of all charges billed in field 24f.
29	Amount paid	Leave blank or enter $0.00. Do not report any client copay or Medicaid payment amounts on this form.
30	Balance due	Enter the balance due as recorded in field 28.
31*	Signature and date	This field must contain an authorized signature and date, which is either hand signed, stamped, or computer generated.
32	Name and address of facility	Enter the name and address of the person, organization, or facility performing the services if other than the client's home or physician's office.
33*	Physician's, supplier's billing name, address, phone number	Enter the name, address, phone number and Montana Medicaid provider number (not UPIN) of the physician or supplier who furnished service.

* = Required Field ** = Required if applicable

Client Has Medicaid Coverage Only

APPROVED OMB-0938-0008

For Medicaid use. Do not write in this area.

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Smith, Chuckie L.

3. PATIENT'S BIRTH DATE: MM 04 DD 28 YY 96 SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 123 Anystreet #1

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: Anytown STATE: MT

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY STATE

ZIP CODE: 59999 TELEPHONE (Include Area Code): (406) 555-5555

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE: 999999999

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 805.0 3. ____ . __

2. ____ . __ 4. ____ . __

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 1234567890

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 09 18 02	09 18 02	41	0	A0429	RH	1	296.31	1				
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]: 99-9999999

26. PATIENT'S ACCOUNT NO.: 99999

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 296.31

29. AMOUNT PAID: $ 0.00

30. BALANCE DUE: $ 296.31

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Maryanne Sable 09/22/02

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Emergency Medical Response
P.O. Box 999
Anytown, MT 59999

PIN# 0000099999 GRP# (406) 555-5555

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE***

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

Client Has Medicaid and Medicare Coverage

Field #	Field Title	Instructions
1	Program	Check Medicaid.
1a*	Insured's ID number	Enter the client's Medicare ID number.
2*	Patient's name	Enter the client's name as it appears on the Medicaid ID card.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check male or female box.
4	Insured's name	Enter the name of the insured or "SAME".
5	Patient's address	Client's address and telephone number.
7	Insured's address	Enter the insured's address and telephone number or "SAME".
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. If you answered "yes" to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on their ID card.
11	Insured's policy group	This field should be blank.
11c	Insurance plan or program	This field should be blank.
11d*	Is there another health benefit plan?	Check "NO".
14	Date of current illness, injury, pregnancy	Enter date in month/day/year format.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year format.
17	Name of referring physician	Enter the name of the referring physician. For PASSPORT clients, the name of the client's PASSPORT provider goes here.
17a	ID number of referring physician	Enter the referring or ordering physician's Medicaid ID number. For PASSPORT clients, enter the client's PASSPORT provider's PASSPORT ID number (UPIN).
18	Hospitalization dates related to current service	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No". Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
23**	Prior authorization number	Enter PA number for scheduled transports. PA is not required for non-scheduled crossover claims.
24a*	Date(s) of service	Enter date(s) of service for each procedure, service, or supply.
24b*	Place of service	Enter the appropriate two-digit place of service (see *Appendix C*).
24c*	Type of service	Enter Montana's type of service code: Nursing facilities are "9", and all others are "0" (zero).
24d*	Procedure, service, or supplies	Enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter appropriate modifiers. Medicaid recognizes two pricing and one informational modifier per code.
24e*	Diagnosis code	Enter the corresponding diagnosis code **reference number** (1, 2, 3 or 4) from field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.
24f*	Charges	Enter your reasonable and customary charges (or the Department-designated charges) for the procedure(s) on this line.
24g*	Days or units	Enter the number of units or days for the procedure and date(s) of service billed on this line (see *Billing Procedures*, *Coding* for additional tips on days/units). Anesthesia providers must bill using minutes.
24h**	EPSDT/family planning	If applicable, enter the appropriate code for the client/service: 1, 2, 3, 4, 5 or 6 (see complete description in the *EPSDT/Family Planning Indicators* table earlier in this chapter).
24i*	EMG (Emergency)	Enter an "X" if this service was rendered in a hospital emergency room to override Medicaid copay.
28	Total charge	Enter the sum of all charges billed in field 24f.
29	Amount paid	Leave this field blank. Do not include any adjustment amounts or coinsurance. The Medicare payment amount will be determined from the EOMB attached to the claim.
30	Balance due	Enter the balance due as listed in field 28.
31*	Signature and date	This field must contain an authorized signature and date, which can be hand signed, stamped, or computer generated.
32	Name and address of facility	Enter the name and address of the person, organization, or facility performing the services if other than the client's home or physician's office.
33*	Physician's, supplier's billing name, address, phone number	Enter the name, address, phone number and Montana Medicaid provider number (not UPIN) of the physician or supplier who furnished service.

* = Required Field ** = Required if applicable

Client Has Medicaid and Medicare Coverage

APPROVED OMB-0938-0008

For Medicaid use. Do not write in this area.

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 999999999A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Jones, Jerry

3. PATIENT'S BIRTH DATE: 02 04 33 SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Same

5. PATIENT'S ADDRESS (No., Street): 4321 Anystreet

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): Same

CITY: Anytown STATE: MT

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY: STATE:

ZIP CODE: 59999 TELEPHONE (Include Area Code): (406) 555-9999

Employed [X] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE: 999999999

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 12 07 01 TO 12 24 01

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 411.1
2. .
3. .
4. .

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 10 01 02	10 01 01	41	0	A0428		1	220 70	1				
2 10 01 02	12 08 01	41	0	A0422		1	18 03	1				
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]: 99-9999999

26. PATIENT'S ACCOUNT NO.: 99999999ABC

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 238 73

29. AMOUNT PAID: $

30. BALANCE DUE: $ 238 73

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Maryanne Sable 10/04/02

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Emergency Medical Response
P.O. Box 999
Anytown, MT 59999

PIN# 0000099999 GRP# (406) 555-5555

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE***

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

Client Has Medicaid and Third Party Liability Coverage

Field #	Field Title	Instructions
1	Program	Check Medicaid.
1a*	Insured's ID number	Enter the client's ID number for the primary carrier.
2*	Patient's name	Enter the client's name as it appears on the Medicaid ID card.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check male or female box.
4	Insured's name	Enter the name of the insured or "SAME".
5	Patient's address	Client's address and telephone number.
7	Insured's address	Enter the insured's address and telephone number or "SAME".
9 -9d	Other insured's information	Use these fields only if there are two or more third party insurance carriers (not including Medicaid and Medicare).
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. If you answered "yes" to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on their ID card.
11	Insured's policy group	Leave this field blank, or enter the client's ID number for the primary payer.
11c*	Insurance plan or program	Enter the name of the other insurance plan or program (i.e. BlueCross BlueShield, New West, etc.).
11d*	Is there another health benefit plan?	Check "YES".
14	Date of current illness, injury, pregnancy	Enter date in month/day/year format.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year format.
17	Name of referring physician	Enter the name of the referring physician. For PASSPORT clients, the name of the client's PASSPORT provider goes here.
17a	ID number of referring physician	Enter the referring or ordering physician's Medicaid ID number. For PASSPORT clients, enter the client's PASSPORT provider's PASSPORT ID number (UPIN).
18	Hospitalization dates related to current service	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No". Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
23*	Prior authorization number	Enter the authorization number assigned by the authorizing agency (not the tracking number).
24a*	Date(s) of service	Enter date(s) of service for each procedure, service, or supply.
24b*	Place of service	Enter the appropriate two-digit place of service (see *Appendix C*).
24c*	Type of service	Enter Montana's type of service code: Nursing facilities are "9", and all others are "0" (zero).
24d*	Procedure, service, or supplies	Enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter appropriate modifiers. Medicaid recognizes two pricing and one informational modifier per code.
24e*	Diagnosis code	Enter the corresponding diagnosis code **reference number** (1, 2, 3 or 4) from field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.
24f*	Charges	Enter your reasonable and customary charges (or the Department-designated charges) for the procedure(s) on this line.
24g*	Days or units	Enter the number of units or days for the procedure and date(s) of service billed on this line (see *Billing Procedures, Coding* for additional tips on days/units). Anesthesia providers must bill using minutes.
24h**	EPSDT/family planning	If applicable, enter the appropriate code for the client/service: 1, 2, 3, 4, 5 or 6 (see complete description in the *EPSDT/Family Planning Indicators* table earlier in this chapter).
24i*	EMG (Emergency)	Enter an "X" if this service was rendered in a hospital emergency room to override Medicaid copay.
28*	Total charge	Enter the sum of all charges billed in field 24f.
29*	Amount paid	Enter the amount paid by the other insurance. Do not include any adjustment amounts or coinsurance.
30*	Balance due	Enter the balance due (the amount in field 28 less the amount in field 29).
31*	Signature and date	This field must contain an authorized signature and date, which can be hand signed, stamped, or computer generated.
32	Name and address of facility	Enter the name and address of the person, organization, or facility performing the services if other than the client's home or physician's office.
33*	Physician's, supplier's billing name, address, phone number	Enter the name, address, phone number and Montana Medicaid provider number (not UPIN) of the physician or supplier who furnished service.

* = Required Field ** = Required if applicable

Client Has Medicaid and Third Party Liability Coverage

APPROVED OMB-0938-0008

PLEASE DO NOT STAPLE IN THIS AREA

For Medicaid use. Do not write in this area.

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 999999999B

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Jackson, Renee P.

3. PATIENT'S BIRTH DATE MM DD YY: 08 31 80 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Same

5. PATIENT'S ADDRESS (No., Street): 4321 Anystreet

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): Same

CITY: Anytown STATE: MT

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY: STATE:

ZIP CODE: 59999 TELEPHONE (Include Area Code): (406)999-9999

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 999999999B

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME: Paywell Insurance

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE: 9999999

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [X] YES [ ] NO ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 804.46
2. .
3. .
4. .

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER: 1234567890

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 10 15 02	10 15 02	41	0	A0427		1	351 86	1				
2 10 15 02	10 15 02	41	0	A0425		1	3 96	1				
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ 355 82

29. AMOUNT PAID $ 220 03

30. BALANCE DUE $ 126 79

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Maryanne Sable 10/18/02

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Emergency Medical Response
P.O. Box 999
Anytown, MT 59999

PIN# 0000099999 GRP# (406) 555-5555

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

Client Has Medicaid, Medicare, and Third Party Liability Coverage

Field #	Field Title	Instructions
1	Program	Check Medicaid.
1a*	Insured's ID number	Enter the client's Medicare ID number.
2*	Patient's name	Enter the client's name as it appears on the Medicaid ID card.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check male or female box.
4	Insured's name	Enter the name of the insured or "SAME".
5	Patient's address	Client's address and telephone number.
7	Insured's address	Enter the insured's address and telephone number or "SAME".
9 -9d	Other insured's information	Use these fields only if there are two or more third party insurance carriers (not including Medicaid and Medicare).
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. If you answered "yes" to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on their ID card.
11*	Insured's policy group	Enter the client's primary payer (TPL) ID number.
11c*	Insurance plan or program	Enter the name of the primary payer.
11d*	Is there another health benefit plan?	Check "YES".
14	Date of current illness, injury, pregnancy	Enter date in month/day/year format.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year format.
17	Name of referring physician	Enter the name of the referring physician. For PASSPORT clients, the name of the client's PASSPORT provider goes here.
17a	ID number of referring physician	Enter the referring or ordering physician's Medicaid ID number. For PASSPORT clients, enter the client's PASSPORT provider's PASSPORT ID number (UPIN).
18	Hospitalization dates related to current service	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No". Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
23**	Prior authorization number	Enter PA number for scheduled transports. PA is not required for non-scheduled crossover claims.
24a*	Date(s) of service	Enter date(s) of service for each procedure, service, or supply.
24b*	Place of service	Enter the appropriate two-digit place of service (see *Appendix C*).
24c*	Type of service	Enter Montana's type of service code: Nursing facilities are "9", and all others are "0" (zero).
24d*	Procedure, service, or supplies	Enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter appropriate modifiers. Medicaid recognizes two pricing and one informational modifier per code.
24e*	Diagnosis code	Enter the corresponding diagnosis code **reference number** (1, 2, 3 or 4) from field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.
24f*	Charges	Enter your reasonable and customary charges (or the Department-designated charges) for the procedure(s) on this line.
24g*	Days or units	Enter the number of units or days for the procedure and date(s) of service billed on this line (see *Billing Procedures*, *Coding* for additional tips on days/units). Anesthesia providers must bill using minutes.
24h**	EPSDT/family planning	If applicable, enter the appropriate code for the client/service: 1, 2, 3, 4, 5 or 6 (see complete description in the *EPSDT/Family Planning Indicators* table earlier in this chapter).
24i*	EMG (Emergency)	Enter an "X" if this service was rendered in a hospital emergency room to override Medicaid copay.
28*	Total charge	Enter the sum of all charges billed in field 24f.
29*	Amount paid	Enter the amount paid by the primary payer (not Medicare). Do not include any adjustment amounts or coinsurance. The Medicare payment amount will be determined from the EOMB attached to the claim.
30*	Balance due	Enter the balance due (the amount in field 28 less the amount in field 29).
31*	Signature and date	This field must contain an authorized signature and date, which can be hand signed, stamped, or computer generated.
32	Name and address of facility	Enter the name and address of the person, organization, or facility performing the services if other than the client's home or physician's office.
33*	Physician's, supplier's billing name, address, phone number	Enter the name, address, phone number and Montana Medicaid provider number (not UPIN) of the physician or supplier who furnished service.

* = Required Field ** = Required if applicable

Client Has Medicaid, Medicare, and Third Party Liability Coverage

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

For Medicaid use. Do not write in this area.

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 999999999A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Olsen, Karen Z.

3. PATIENT'S BIRTH DATE MM DD YY: 11 07 62 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Same

5. PATIENT'S ADDRESS (No., Street): 98765 Anystreet #2

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): Same

CITY: Anytown STATE: MT

8. PATIENT STATUS: Single [X] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: STATE:

ZIP CODE: 59999 TELEPHONE (Include Area Code): (406) 999-9999

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 999999999B

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: Paywell Insurance

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE: 999999999

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 410.01
2. .
3. .
4. .

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 10 16 02	10 16 02	41	0	A0427		1	351 86	1				
2 10 16 02	10 16 02	41	0	93041		1	7 13	1				
3 10 16 02	10 16 02	41	0	A0422		1	42 99	1				
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]: 99-9999999

26. PATIENT'S ACCOUNT NO.:

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 401 98

29. AMOUNT PAID: $ 322 16

30. BALANCE DUE: $ 79 82

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Maryanne Sable 10/22/02

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Emergency Medical Response
P.O. Box 999
Anytown, MT 59999

PIN# 0000099999 GRP# (406) 555-5555

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

Client Has Medicaid, Medicare, and Medicare Supplement Coverage

Field #	Field Title	Instructions
1	Program	Check Medicaid.
1a*	Insured's ID number	Enter the client's Medicare ID number.
2*	Patient's name	Enter the client's name as it appears on the Medicaid ID card.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check male or female box.
4	Insured's name	Enter the name of the insured or "SAME".
5	Patient's address	Client's address and telephone number.
7	Insured's address	Enter the insured's address and telephone number or "SAME".
9 -9d	Other insured's information	Use these fields only if there are two or more third party insurance carriers (not including Medicaid and Medicare).
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. If you answered "yes" to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on their ID card.
11*	Insured's policy group	Enter the client's ID number for the primary payer.
11c*	Insurance plan or program	Enter the name of the other insurance plan or program (i.e. BlueCross BlueShield, New West, etc.).
11d*	Is there another health benefit plan?	Check "YES".
14	Date of current illness, injury, pregnancy	Enter date in month/day/year format.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year format.
17	Name of referring physician	Enter the name of the referring physician. For PASSPORT clients, the name of the client's PASSPORT provider goes here.
17a	ID number of referring physician	Enter the referring or ordering physician's Medicaid ID number. For PASSPORT clients, enter the client's PASSPORT provider's PASSPORT ID number (UPIN).
18	Hospitalization dates related to current service	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No". Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
23**	Prior authorization number	Enter PA number for scheduled transports. PA is not required for non-scheduled crossover claims.
24a*	Date(s) of service	Enter date(s) of service for each procedure, service, or supply.
24b*	Place of service	Enter the appropriate two-digit place of service (see *Appendix C*).
24c*	Type of service	Enter Montana's type of service code: Nursing facilities are "9", and all others are "0" (zero).
24d*	Procedure, service, or supplies	If applicable, enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter appropriate modifiers. Medicaid recognizes two pricing and one informational modifier per code.
24e*	Diagnosis code	Enter the corresponding diagnosis code **reference number** (1, 2, 3 or 4) from field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.
24f*	Charges	Enter your reasonable and customary charges (or the Department-designated charges) for the procedure(s) on this line.
24g*	Days or units	Enter the number of units or days for the procedure and date(s) of service billed on this line (see *Billing Procedures*, *Coding* for additional tips on days/units). Anesthesia providers must bill using minutes.
24h**	EPSDT/family planning	Enter the appropriate code for the client/service: 1, 2, 3, 4, 5 or 6 (see complete description in the *EPSDT/Family Planning Indicators* table earlier in this chapter).
24i*	EMG (Emergency)	Enter an "X" if this service was rendered in a hospital emergency room to override Medicaid copay.
28*	Total charge	Enter the sum of all charges billed in field 24f.
29*	Amount paid	Enter the amount paid by the Medicare supplement insurance only. Do not include any adjustment amounts or coinsurance. Medicare payment is determined from the EOMB attached to the claim.
30*	Balance due	Enter balance due (amount in field 28 less the amount in field 29).
31*	Signature and date	This field must contain an authorized signature and date, which can be hand signed, stamped, or computer generated.
32	Name and address of facility	Enter the name and address of the person, organization, or facility performing the services if other than the client's home or physician's office.
33*	Physician's, supplier's billing name, address, phone number	Enter the name, address, phone number and Montana Medicaid provider number (not UPIN) of the physician or supplier who furnished service.

* = Required Field ** = Required if applicable

Client Has Medicaid, Medicare, and Medicare Supplement Coverage

APPROVED OMB-0938-0008

PLEASE DO NOT STAPLE IN THIS AREA

For Medicaid use. Do not write in this area.

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 999999999A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Smith, George P.

3. PATIENT'S BIRTH DATE: 05 13 35 SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Same

5. PATIENT'S ADDRESS (No., Street): 123 Sun City Road

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): Same

CITY: Anytown STATE: MT

8. PATIENT STATUS: Single [X] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: STATE:

ZIP CODE: 59999 TELEPHONE (Include Area Code): (406) 555-5555

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 999999999B

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY SEX: M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX: M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: Paywell Supplemental Insurance

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE: 999999999

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 786.09 3. ____.__

2. ____.__ 4. ____.__

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 11 02 02	11 02 02	41	0	A0427		1	351 86	1				
2 11 02 02	11 02 02	41	0	A0425		1	15 84	4				
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER: 99-9999999 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.:

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 367 70

29. AMOUNT PAID: $ 322 19

30. BALANCE DUE: $ 45 51

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Maryanne Sable 11/05/02

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Emergency Medical Response
P.O. Box 999
Anytown, MT 59999

PIN# 0000099999 GRP# (406) 555-5555

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

CMS-1500 Agreement

Your signature on the CMS-1500 constitutes your agreement to the terms presented on the back of the form. This form is subject to change by the Centers for Medicare and Medicaid Services (CMS).

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION

(PRIVACY ACT STATEMENT)

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing date sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to HCFA, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (OMB-0938-0008), Washington, D.C. 20503.

Avoiding Claim Errors

Claims are often returned to the provider before they can be processed or denied after processing. To avoid denials and returns, double check each claim form to confirm the following items are accurate. For more information on returned and denied claims, see the *Billing Procedures* chapter in this manual.

Common Claim Errors

Claim Error	Prevention
Required field is blank	Check the claim instructions earlier in this chapter for required fields (indicated by * or **). If a required field is blank, the claim may either be returned or denied.
Client ID number missing or invalid	This is a required field (field 10d); verify that the client's Medicaid ID number is listed as it appears on the client's ID card.
Client name missing	This is a required field (field 2); check that it is correct.
Medicaid provider number missing or invalid	The provider number is a 7-digit number assigned to the provider during Medicaid enrollment. Verify the correct **Medicaid** provider number is on the claim.
Prior authorization number missing	Authorization is required for all transports (except non-scheduled Medicare crossovers), and the authorization number must be listed on the claim in field 23 (see the *Authorization* chapter in this manual).
Not enough information regarding other coverage	Fields 1a and 11d are required fields when a client has other coverage (refer to the examples earlier in this chapter).
Authorized signature missing	Each claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be typed, stamped, or hand-written.
Signature date missing	Each claim must have a signature date.
Incorrect claim form used	Services covered in this manual require a CMS-1500 claim form.
Information on claim form not legible	Information on the claim form must be legible. Use dark ink and center the information in the field. Information must not be obscured by lines.
Medicare EOMB not attached	When Medicare is involved in payment on a claim, the Medicare EOMB must be attached to the claim or it will be denied.

Other Programs

The information in this chapter does not apply to the Mental Health Services Plan (MHSP) or the Children's Health Insurance Plan (CHIP). The MHSP manual is available on the Provider Information website (see *Key Contacts*). The CHIP Medical Manual is available through BlueCross BlueShield at (800) 447-7828 X8647.

MONTANA
Department of Public Health & Human Services

Remittance Advices and Adjustments

Remittance Advice Description

The remittance advice (RA) is the best tool providers have to determine the status of a claim. RAs accompany payment for services rendered. The RA provides details of all transactions that have occurred during the previous remittance advice cycle. Providers may select a one or two week payment cycle (see *Payment and the RA* later in this chapter). Each line of the remittance advice represents all or part of a claim, and explains whether the claim has been paid, denied, or suspended (pending). If the claim was suspended or denied, the RA also shows the reason. See the sample RA on the following page.

RA notice

The RA notice is on the first page of the remittance advice. This section contains important messages about rate changes, revised billing procedures, and many other items that affect providers and claims.

Paid claims

This section shows claims paid during the previous cycle. It is the provider's responsibility to verify that claims were paid correctly. If Medicaid overpays a claim and the problem is not corrected, it may result in an audit and the provider returning the overpayment plus interest. If a claim was paid at the wrong amount or with incorrect information, the claim must be adjusted (see *Adjustments* later in this chapter).

Denied claims

This section shows claims denied during the previous cycle. If a claim has been denied, refer to the EOB CODES column (Field 16). The EOB code description explains why the claim was denied and is located at the end of the RA. See *The Most Common Billing Errors and How to Avoid Them* in the *Billing Procedures* chapter. Please make necessary changes to the claim before rebilling Medicaid.

Pending claims

All claims that have not reached final disposition will appear in this area of the RA. The RA uses "suspended" and "pending" interchangeably. They both mean that the claim has not reached final disposition. If a claim is pending, refer to the EOB CODES column (Field 16). The EOB code description located at the end of the RA will explain why the claim is suspended. This section is informational only. Please do not take any action on claims displayed here. Processing will continue until each claim is paid or denied.

It is the provider's responsibility to follow up with all claims and make sure all problems are resolved within the twelve-month timely filing limit (see the *Billing Procedures* chapter in this manual).

If a claim was denied, please read the description of the EOB before taking any action on the claim.

The pending claims section of the RA is informational only. Please do not take any action on claims displayed here.

Sample Remittance Advice

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES
HELENA, MT 59604

MEDICAID REMITTANCE ADVICE (1)

EMERGENCY MEDICAL RESPONSE
P.O. BOX 999
ANYTOWN MT 59999

(2) PROVIDER# 0001234567 (3) REMIT ADVICE #123456 (4) WARRANT # 654321 (5) DATE:09/27/02 PAGE 2 (6)

RECIP ID (7)	NAME (8)	SERVICE DATES FROM TO (10)	UNIT OF SVC (11)	PROCEDURE REVENUE NDC (12)	TOTAL CHARGES (13)	ALLOWED (14)	CO-PAY (15)	EOB CODES (16)
PAID CLAIMS - MISCELLANEOUS CLAIMS								
123456789	DOE, JOHN EDWARD	091802 091802	1	A0429	296.31	197.54	N	
(9) ICN	00204011250000700	999999999A						
		LESS MEDICARE PAID*******				159.32 (17)		
		CLAIM TOTAL*******			296.31	38.22		
DENIED CLAIMS - MISCELLANEOUS CLAIMS								
123456788	DOE, JOE HENRY	092002 092002	1	A0428	220.70	0.00	N	
ICN	00204011250000800	ADDITIONAL EOB: 082 (16)						
		092002 092002	1	A0422	18.03	0.00 (17)	N	
		CLAIM TOTAL*******			238.73			048
PENDING CLAIMS - MISCELLANEOUS CLAIMS								
123456787	DOE, JANE ANN	092202 092202	1	A0427	351.86	0.00 (17)	N	901
ICN	00204011250000900	092202 092202	1	A0425	3.96	0.00	N	901
		CLAIM TOTAL*******			355.82			

**********THE FOLLOWING IS A DESCRIPTION OF THE EOB CODES THAT APPEAR ABOVE**********

082 THE PLACE OF SERVICE CODE BILLED IS NOT VALID FOR THE PROCEDURE CODE BILLED. PLEASE VERIFY THE ACCURACY OF THE PLACE OF SERVICE AND PROCEDURE CODES PRIOR TO CONTACTING ACS FOR ASSISTANCE.

048 CLAIM DENIED. WE HAVE NO MEDICAID ELIGIBILITY ON FILE FOR THIS PATIENT FOR THE DATES OF SERVICE ON THE CLAIM. CHECK THE DATES OF SERVICE AND REFER TO THE ID CARD OR THE PATIENT FOR CORRECT ELIGIBILITY INFORMATION BEFORE RESUBMITTING. IF YOU HAVE DOCUMENTATION OF ELIGIBILITY OR A ONE-DAY AUTHORIZATION, YOU WILL NEED TO CONTACT THE CLIENT'S COUNTY OFFICE OF HUMAN SERVICES (WELFARE OFFICE) TO HAVE THE PROBLEM CORRECTED.

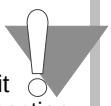
901 CLAIM SUSPENDED FOR A MAXIMUM OF 30 DAYS PENDING RECEIPT OF RECIPIENT ELIGIBILITY INFORMATION.

Key Fields on the Remittance Advice

Field	Description
1. Provider name and address	Provider's business name and address as recorded with the Department
2. Provider number	The 7-digit number assigned to the provider by Medicaid (often with 3 leading zeros)
3. Remittance advice number	The remittance advice number
4. Warrant number	Not used
5. Date	The date the RA was issued
6. Page Number	The page number of the RA
7. Recipient ID	The client's Medicaid ID number
8. Name	The client's name
9. Internal control number (ICN)	Each claim is assigned a unique 17-digit number (ICN). Use this number when you have any questions concerning your claim. The claim number represents the following information: 0 00111 00 123 000123 A B C D E A = Claim medium 0 = Paper claim 2 = Electronic claim 3 = Encounter claim 4 = System generated claim (mass adjustment, nursing home turn-around document, or point-of-sale (POS) pharmacy claim) B = Julian date (e.g. April 20, 2000 was the 111th day of 2000) C = Microfilm number 00 = Electronic claim 11 = Paper claim D = Batch number E = Claim number If the first number is: 0 = Regular claim 1 = Negative side adjustment claim (Medicaid recovers payment) 2 = Positive side adjustment claim (Medicaid reprocesses)
10. Service dates	Date(s) services were provided. If service(s) were performed in a single day, the same date will appear in both columns
11. Unit of service	The units of service rendered for this procedure or prescription.
12. Procedure/revenue/NDC	The procedure code (CPT, HCPCS, or local), National Drug Code (NDC), or revenue code will appear in this column. If a modifier was used, it will also appear in this column.
13. Total charges	The amount the provider billed for this service.
14. Allowed	The Medicaid allowed amount.
15. Copay	A "Y" indicates cost sharing was deducted from the allowed amount, and an "N" indicates cost sharing was not deducted.
16. EOB codes (Explanation of Benefits)	A 3-digit code which explains why the specific service was denied or pended. Descriptions of these codes are listed at the end of the RA.
17. Deductions, billed amount, and paid amount	Any deductions, such as cost sharing or third party liability are listed first. The amount the provider billed is next, followed by the amount of Medicaid reimbursement.

Claims shown as pending with EOB code 900 require additional review before a decision to pay or deny is made.

Claims shown as pending with EOB code 901 are held while waiting for client eligibility information. The claims will be suspended for a maximum of 30 days. If eligibility information is received by Medicaid within the 30-day period, the claim will continue processing. If eligibility information is not received within 30 days, the claim will be denied. When a claim is denied for lack of eligibility, the provider should verify that the correct Medicaid ID number was billed. If the ID number was incorrect, resubmit the claim with the correct ID number.



The credit balance section is informational only. Do not post from credit balance statements.

Credit balances

Credit balances occur when claim adjustments reduce original payments causing the provider to owe money to the Department. These claims are considered in process and continue to appear on the RA until the credit has been satisfied.

Credit balances can be resolved in two ways:

1. By "working off" the credit balance. Remaining credit balances can be deducted from future claims. These claims will continue to appear on consecutive RAs until the credit has been paid.
2. By sending a check payable to DPHHS for the amount owed. This method is required for providers who no longer submit claims to Montana Medicaid. Please attach a note stating that the check is to pay off a credit balance and include your provider number. Send the check to the attention of the *Provider Relations Field Representative* at the Provider Relations address in *Key Contacts*.

Medicaid does not accept any claim for resubmission or adjustment after 12 months from the date of service (see *Timely Filing Limits* in *Billing Procedures* chapter).

Rebilling and Adjustments

Rebillings and adjustments are important steps in correcting any billing problems you may experience. Knowing when to use the rebilling process versus the adjustment process is important.

How long do I have to rebill or adjust a claim?

- Providers may resubmit or adjust any initial claim within the timely filing limits described in the *Billing Procedures* chapter of this manual.
- These time periods do not apply to overpayments that the provider must refund to the Department. After the 12 month time period, a provider may not refund overpayments to the Department by completing a claim adjustment. The provider may refund overpayments by issuing a check or requesting Provider Relations to complete a gross adjustment.

Rebilling Medicaid

Rebilling is when a provider submits a claim (or claim line) to Medicaid that was previously submitted for payment but was either returned or denied. Claims are often returned to the provider before processing because key information such as Medicaid provider number or authorized signature and date are missing or unreadable. For tips on preventing returned or denied claims, see the *Billing Procedures* and *Completing a Claim* chapters.

When to rebill Medicaid

Rebill denied claims only after appropriate corrections have been made.

- ***Claim Denied.*** Providers can rebill Medicaid when a claim is denied in full, as long as the claim was denied for reasons that can be corrected. When the entire claim is denied, check the Explanation of Benefits (EOB) code, make the appropriate corrections, and resubmit the claim on a CMS-1500 form (not the adjustment form).
- ***Line Denied.*** When an individual line is denied on a multiple-line claim, correct any errors and rebill Medicaid. Either submit the denied service on a new CMS-1500 form, or cross out paid lines and resubmit the form. Do not use an adjustment form.
- ***Claim Returned.*** Rebill Medicaid when the claim is returned under separate cover. Occasionally, Medicaid is unable to process the claim and will return it to the provider with a letter stating that additional information is needed to process the claim. Correct the information as directed and resubmit your claim.

How to rebill

- Check any EOB code listed and make your corrections on a copy of the claim, or produce a new claim with the correct information.
- When making corrections on a copy of the claim, remember to cross out or omit all lines that have already been paid. The claim must be neat and legible for processing.
- Enter any insurance (TPL) information on the corrected claim, or attach insurance denial information to the corrected claim, and send it to Claims Processing (see *Key Contacts*).

Adjustments

If a provider believes that a claim has been paid incorrectly, the provider may call Provider Relations (see *Key Contacts*) or submit a claim inquiry for review (see *Billing Procedures, Claim Inquiries*). Once an incorrect payment has been verified, the provider may submit an *Individual Adjustment Request* form (in *Appendix D*) to Provider Relations. If incorrect payment was the result of a keying error by the claims processing contractor, contact Provider Relations.

Adjustments can only be made to paid claims.

When adjustments are made to previously paid claims, the Department recovers the original payment and issues appropriate repayment. The result of the adjustment appears on the provider's RA as two transactions. The original payment will appear as a credit transaction. The replacement claim reflecting the corrections will be listed as a separate transaction and may or may not appear on the same RA as the credit transaction. The replacement transaction will have nearly the same ICN number as the credit transaction, except the 12th digit will be a 2, indicating an adjustment. See *Key Fields on the Remittance Advice* earlier in this chapter. Adjustments are processed in the same time frame as claims.

When to request an adjustment

- Request an adjustment when a claim was overpaid or underpaid.
- Request an adjustment when a claim was paid but the information on the claim was incorrect (such as client ID, provider number, date of service, procedure code, diagnoses, units, etc.).

How to request an adjustment

To request an adjustment, use the *Montana Medicaid Individual Adjustment Request* form in *Appendix D*. The requirements for adjusting a claim are as follows:

- Claims Processing must receive individual claim adjustment requests within 12 months from the date of service (see *Timely Filing Limits* in the *Billing Procedures* chapter). After this time, *gross adjustments* are required (see *Definitions*).
- Use a separate adjustment request form for each ICN.
- If you are correcting more than one error per ICN, use only one adjustment request form, and include each error on the form.
- If more than one line of the claim needs to be adjusted, indicate which lines and items need to be adjusted in the *Remarks* section of the adjustment form.

Completing an Adjustment Request Form

1. Copy the *Montana Medicaid Individual Adjustment Request* form from *Appendix D*. You may also order forms from Provider Relations or download them from the *Provider Information* website (see *Key Contacts*). Complete Section A first with provider and client information and the claim's ICN number (see following table and sample AR).
2. Complete Section B with information about the claim. Remember to fill in only the items that need to be corrected (see following table):
   - Enter the date of service or the line number in the *Date of Service or Line Number* column.

- Enter the information from the claim form that was incorrect in the *Information on Statement* column.
- Enter the correct information in the column labeled *Corrected Information*.

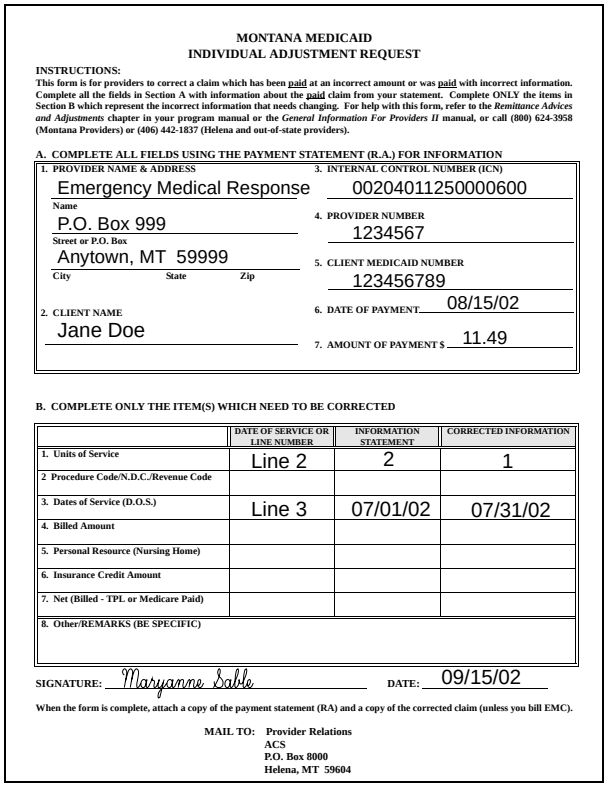
Completing an Individual Adjustment Request Form

Field	Description
Section A	
1. Provider name and address	Provider's name and address (and mailing address if different).
2. Recipient name	The client's name is here.
3.* Internal control number (ICN)	There can be only one ICN per adjustment request form. When adjusting a claim that has been previously adjusted, use the ICN of the most recent claim.
4.* Provider number	The provider's Medicaid ID number.
5.* Recipient Medicaid number	Client's Medicaid ID number.
6. Date of payment	Date claim was paid is found on remittance advice field #5 (see the sample RA earlier in this chapter).
7. Amount of payment	The amount of payment from the remittance advice field #17 (see the sample RA earlier in this chapter.).
Section B	
1. Units of service	If a payment error was caused by an incorrect number of units, complete this line.
2. Procedure code/ NDC/ Revenue code	If the procedure code, NDC, or revenue code is incorrect, complete this line.
3. Dates of service (D.O.S)	If the date(s) of service is incorrect, complete this line.
4. Billed amount	If the billed amount is incorrect, complete this line.
5. Personal resource (Nursing facility)	If the client's personal resource amount is incorrect, complete this line.
6. Insurance credit amount	If the client's insurance credit amount is incorrect, complete this line.
7. Net (Billed – TPL or Medicare paid)	If the payment error was caused by a missing or incorrect insurance credit, complete this line. Net is billed amount minus the amount third party liability or Medicare paid.
8. Other/Remarks	If none of the above items apply, or if you are unsure what caused the payment error, complete this line.

* Indicates a required field

3. Attach copies of the RA and a corrected claim if necessary.
   - If the original claim was billed electronically, a copy of the RA will suffice.
   - If the RA is electronic, attach a screen print of the RA.
4. Verify the adjustment request has been signed and dated.
5. Send the adjustment request to Claims Processing (see *Key Contacts*).

- If an original payment was an underpayment by Medicaid, the adjustment will result in the provider receiving the additional payment amount.



MONTANA MEDICAID
INDIVIDUAL ADJUSTMENT REQUEST

INSTRUCTIONS:
This form is for providers to correct a claim which has been paid at an incorrect amount or was paid with incorrect information. Complete all the fields in Section A with information about the paid claim from your statement. Complete ONLY the items in Section B which represent the incorrect information that needs changing. For help with this form, refer to the *Remittance Advices and Adjustments* chapter in your program manual or the *General Information For Providers II* manual, or call (800) 624-3958 (Montana Providers) or (406) 442-1837 (Helena and out-of-state providers).

A. COMPLETE ALL FIELDS USING THE PAYMENT STATEMENT (R.A.) FOR INFORMATION

1. PROVIDER NAME & ADDRESS
Name: Emergency Medical Response
Street or P.O. Box: P.O. Box 999
City State Zip: Anytown, MT 59999
2. CLIENT NAME: Jane Doe
3. INTERNAL CONTROL NUMBER (ICN): 00204011250000600
4. PROVIDER NUMBER: 1234567
5. CLIENT MEDICAID NUMBER: 123456789
6. DATE OF PAYMENT: 08/15/02
7. AMOUNT OF PAYMENT $: 11.49

B. COMPLETE ONLY THE ITEM(S) WHICH NEED TO BE CORRECTED

	DATE OF SERVICE OR LINE NUMBER	INFORMATION STATEMENT	CORRECTED INFORMATION
1. Units of Service	Line 2	2	1
2 Procedure Code/N.D.C./Revenue Code			
3. Dates of Service (D.O.S.)	Line 3	07/01/02	07/31/02
4. Billed Amount			
5. Personal Resource (Nursing Home)			
6. Insurance Credit Amount			
7. Net (Billed - TPL or Medicare Paid)			
8. Other/REMARKS (BE SPECIFIC)			

SIGNATURE: Maryanne Sable DATE: 09/15/02

When the form is complete, attach a copy of the payment statement (RA) and a copy of the corrected claim (unless you bill EMC).

MAIL TO: Provider Relations
ACS
P.O. Box 8000
Helena, MT 59604

Sample Adjustment Request

- If an original payment was an overpayment by Medicaid, the adjustment will result in recovery of the overpaid amount through a credit balance or a check from the provider (see *Credit balances* earlier in this chapter).
- Any questions regarding claims or adjustments must be directed to Provider Relations (see *Key Contacts*).

Mass adjustments

Mass adjustments are done when it is necessary to reprocess multiple claims. They generally occur when:

- Medicaid has a change of policy or fees that is retroactive.
- A system error that affected claims processing is identified.

Providers are informed of mass adjustments by a Provider Notice or on the first page of the remittance advice (RA Notice section). Mass adjustment claims shown on the RA have an ICN that begins with a "4" (see *Key Fields on the Remittance Advice* earlier in this chapter).

Payment and The RA

Providers may receive their Medicaid payment and remittance advice either weekly or biweekly. Payment can be via check or electronic funds transfer (EFT). Direct deposit is another name for EFT. Providers who wish to receive weekly payment must request both EFT and electronic RAs and specifically request weekly payment. For biweekly payment, providers can choose any combination of paper/electronic payment method and RA.

Electronic Funds Transfer

With EFT, the Department deposits the funds directly to the provider's bank account. If the scheduled deposit day is a holiday, funds will be available on the next business day. This process does not affect the delivery of the remittance advice that providers currently receive with payments. RAs will continue to be mailed to providers unless they specifically request an electronic RA.

Weekly payments are available only to providers who receive both EFT **and** electronic RAs.

To participate in EFT, providers must complete a *Direct Deposit Sign-Up Form* (Standard Form 1199A) (see the following table). One form must be completed for each provider number.

Once electronic transfer testing shows payment to the provider's account, all Medicaid payments will be made through EFT. See *Direct Deposit Arrangements* under *Key Contacts* for questions or changes regarding EFT.

Electronic Remittance Advice

To receive an electronic RA, the provider must have internet access. The electronic RA is accessed through the Montana Eligibility and Payment System (MEPS) on the internet through the Virtual Human Services Pavilion (see *Key Contacts*). In order to access MEPS, you must complete an *Access Request Form* (see the following table).

Electronic RAs are available for only six weeks on MEPS.

After this form has been processed, you will receive a password. Entry into the system requires a valid provider or group number and password. Each provider or group number requires a unique password, so providers must complete a separate request form for each provider or group.

RAs are available from MEPS in PDF and flat file format. You can read, print, or download PDF files using Adobe Acrobat Reader, which is available on the "SOR Download" page. The file layout for flat files is also available on the SOR download page. Due to space limitations, each RA is only available for six weeks.

Required Forms For EFT and/or Electronic RA

All three forms are required for a provider to receive weekly payment

Form	Purpose	Where to Get	Where to Send
Electronic Remittance Advice and Payment Cycle Enrollment Form	Allows provider to receive electronic remittance advices on MEPS (must also include MEPS Access Request form)	• Provider Relations* • Provider Information website*	Provider Relations*
Direct Deposit Sign-up Form 1199A Standard	Allows the Department to automatically deposit Medicaid payment into provider's bank account	• Provider's bank • Provider Information website*	Provider Relations*
MEPS Access Request Form	Allows provider to receive a password to access their RA on MEPS	• Virtual Human Services Pavilion* • Direct Deposit Arrangements* • Provider Information website*	DPHHS address on the form

* Information on this contact is available in the *Key Contacts* section of this manual.

Other Programs

The information in this chapter does not apply to the Mental Health Services Plan (MHSP) or the Children's Health Insurance Plan (CHIP). The MHSP manual is available on the Provider Information website (see *Key Contacts*). The CHIP Medical Manual is available through BlueCross BlueShield at (800) 447-7828 X8647.

How Payment Is Calculated

Overview

Though providers do not need the information in this chapter in order to submit claims to the Department, the information allows providers to understand how payment is calculated and to predict approximate payment for particular claims.

The Ambulance Fee Schedule

The Medicaid payment method is based on, and very similar to, the Medicare payment method that was implemented for Montana providers on April 1, 2002. Both take a fee schedule approach, with set fees shown for specific services. Fees may be updated at any time, but are most commonly changed at the start of the state fiscal year, July 1. For the latest list of specific covered services and fees, providers should check the Medicaid ambulance fee schedule. It is available on the Provider Relations website or by calling Provider Relations (see *Key Contacts*).

Although Medicaid payment methods are based on Medicare, there are differences. In these cases, the Medicaid method prevails.

Payment for Ground Ambulance Services

Medicaid pays different fees for different levels of service, as described more specifically in the *Billing Procedures* chapter in this manual. These levels of service are intended to be the same as Medicare uses.

Each ground ambulance base rate is the product of relative value units and a conversion factor. The relative values are adopted from the Medicare program, which developed them after extensive data analysis and consultation at the national level. The relative value for each service is then multiplied by a Medicaid-specific conversion factor to derive the fee. As of July 1, 2002, the Medicaid conversion factor was $120.25; the conversion factor was originally set to be approximately budget neutral compared with the previous payment method.

For example, the fee for BLS emergency service on July 1, 2002, was 1.6 relative value units x $120.25 = $192.40

When Medicaid payment differs from the fee schedule, consider the following:

- The Department pays the lower of the established Medicaid fee or the provider's charge
- Date of service (fees for services may change over time)
- Also check for cost sharing and Medicare or TPL payments which will be shown on the Remittance Advice.

Payment for Air Ambulance Services

Medicaid pays the same fee for airplane and helicopter transports; the goal is to encourage providers to use whichever mode is most economical for a particular transport. (Helicopter mileage is paid at a higher rate than airplane mileage, however.)

Payment for Mileage

Medicaid pays a separate fee for mileage; unlike Medicare, the fee is the same regardless of distance and rural/urban setting.

Payment for Separately Billable Supplies and Services

Medicaid will pay separately for specific supplies and services, such as oxygen, disposable supplies, drugs, and taking an EKG. The specific services are listed in the fee schedule. Where fees are set, they are usually similar to what Medicaid pays in other settings. Some supplies are paid by report, that is, at a percentage of the provider's charge. The percentage is the same as the "by report" percentage used in the physician program, which itself equals the average payment-to-charge ratio for physician services. As of July 2002 the percentage was 51%; the Department typically reviews this percentage each July.

No Payment for Incidental Services and Supplies

If a service or supply provided during a transport is not specifically listed in the fee schedule, then payment is considered part of the ambulance service. Examples are medical direction by a physician and ambulance decontamination. These additional supplies and services are therefore not separately billable to the client even though Medicaid makes no payment for them specifically.

Charge Cap

For the services covered in this manual, Medicaid pays the lower of the Medicaid fee or the provider's charge.

Multiple Patients

When more than one client is transported during the same trip, Medicaid will cover one base rate per client and one mileage charge per transport. This policy is a simpler version of the Medicare policy.

No Geographic Differential

Medicaid pays the same rates across Montana. Medicare, by contrast, has different urban and rural rates to reflect the wide variance in localities across the U.S.

No Transition Period

Medicaid implemented its new payment method July 1, 2001, without a transition period. Medicare's new method will not be fully implemented until January 1, 2006.

How Payment is Calculated on TPL Claims

When a client has coverage from both Medicaid and another insurance company, the other insurance company is often referred to as third party liability or TPL. In these cases, the other insurance is the primary payer (as described in the C*oordination of Benefits* chapter of this manual), and Medicaid makes a payment as the secondary payer. For example, an ambulance provides a BLS emergency transport (A0429) to a client who also has insurance through her job. The client's other insurance is billed first and pays $174.43. The Medicaid allowed amount for this service is $192.40. The amount the other insurance paid ($174.43) is subtracted from the Medicaid allowed amount ($192.40), leaving a balance of $17.97, which Medicaid will pay on this claim.

How Payment is Calculated on Medicare Crossover Claims

When a client has coverage from both Medicaid and Medicare, Medicare is the primary payer as described in the *Coordination of Benefits* chapter of this manual. Medicaid then makes a payment as the secondary payer. For the ambulance services covered in this manual, Medicaid's payment is calculated so that the total payment to the provider is either the Medicaid allowed amount less the Medicare paid amount or the sum of the Medicare coinsurance and deductible, whichever is lower. This method is sometimes called "lower of" pricing. The following scenarios are examples of how a Medicare crossover claim is paid. Medicaid incurment is not considered in the following examples. These are only examples and may not reflect current rates.

Scenario 1: Dually eligible client who has met Medicare deductible.

An ambulance provides a BLS non emergency transport (A0428) to a client who is eligible for Medicare and Medicaid. The Medicare allowed amount is $155.74, which Medicare pays at 80% for $124.59. This leaves the client with $31.15 Medicare coinsurance.

Scenario 1

$155.74 Medicare allow.
x 80% Medicare rate
$124.59 Medicare paid

$155.74 Medicare allow.
-124.59 Medicare paid
$ 31.15 Medicare coinsurance

$120.25 Medicaid allow.
- 124.59 Medicare paid
$ -4.34 Negative value = 0

$0 < $31.15
$0 Medicaid pays

The Medicaid allowed amount is $120.25. Because Medicare paid $124.59, this would leave a difference of $-4.34. Medicaid considers this negative value equal to $0. Medicaid then compares the coinsurance balance ($31.15) to the Medicaid balance ($0) and pays the lower of the two amounts. Medicaid would pay the provider $0.00 for this claim.

Providers cannot bill Medicaid clients for the difference between charges and the amount Medicaid paid.

Total payment to the provider from all sources may not exceed the Medicaid allowed amount.

Scenario 2: Dually eligible client who has not met Medicare deductible.

An ambulance provides a ALS1-emergency transport to a client who is eligible for both Medicare and Medicaid. The client has not yet met his $100 Medicare deductible. The Medicare allowed amount for this service (A0427) is $295.90. Since the client owes $100 for the deductible, Medicare pays 80% of the remaining $195.90 ($156.72), leaving the client liable for Medicare coinsurance of $39.18.

Medicaid considers the $100 that was applied to the client's Medicare deductible and adds it to the $39.18 coinsurance for a total of $139.18. Medicaid then subtracts the amount Medicare paid ($156.72) from the Medicaid allowed amount ($228.47) for a total of $71.75. Medicaid compares the $139.18 to the $71.75, and pays the lower of the two amounts. Medicaid will pay the provider $71.75 for this claim.

Scenario 2

$295.90 Medicare allow.
-100.00 Medicare deductible
$195.90 Medicare balance

$195.90 Medicare balance
x 80% Medicare rate
$156.72 Medicare paid

$195.90 Medicare balance
-156.72 Medicare paid
$ 39.18 Medicare coinsurance

$100.00 Medicare deductible
+ 39.18 Medicare coinsurance
$139.18

$228.47 Medicaid allow.
-156.72 Medicare paid
$ 71.75

$71.75 < $139.18
$ 71.75 Medicaid paid

Other Programs

The information in this chapter does not apply to the Mental Health Services Plan (MHSP) or the Children's Health Insurance Plan (CHIP). The MHSP manual is available on the Provider Information website (see *Key Contacts*). The CHIP Medical Manual is available through BlueCross BlueShield at (800) 447-7828 X8647.

Appendix A:

Ambulance Trip Log

AMBULANCE TRIP LOG

INITIAL REPORT FORM FOR NON-SCHEDULED TRANSPORTS

Verify Medicaid Eligibility then FAX to the Mountain-Pacific Quality Health Foundation at: 800-291-7791 within 60 days of transport.

Ambulance Name: _____ Provider # _____ Phone: ( )_____

Date:_____ Ambulance Contact Person: _____ FAX#: ( )_____

Patient's Name	Medicaid Number	Sex	Date of Birth	Date of Service	Level of Service	From To	Medical Reason for Transport

Page _____ of _____

Appendix B

Montana Medicaid Claim Inquiry Form

Montana Medicaid Claim Inquiry Form

Provider Name _____
Contact Person _____
Address _____
Date _____
Phone Number _____
Fax Number _____

For status on a claim, please complete the information on this form and mail to the address below or fax to the number shown. You may attach a copy of the claim, but it is not required.

Provider number _____	ACS Response: _____
Client number _____	_____
Date of service _____	_____
Total billed amount _____	_____
Date submitted for processing _____	_____
	_____
Provider number _____	ACS Response: _____
Client number _____	_____
Date of service _____	_____
Total billed amount _____	_____
Date submitted for processing _____	_____
	_____
Provider number _____	ACS Response: _____
Client number _____	_____
Date of service _____	_____
Total billed amount _____	_____
Date submitted for processing _____	_____
	_____

Mail to: Provider Relations
P.O. Box 8000
Helena, MT 59604

Fax to: (406) 442-4402

Appendix C

Place of Service Codes

Place of Service Codes

Codes	Names	Descriptions
01	Pharmacy**	A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.
02	Unassigned	N/A
03	School	A facility whose primary purpose is education.
04	Homeless shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).
05	Indian Health Service free-standing facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.
06	Indian Health Service provider-based facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.
07	Tribal 638 free-standing facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization.
08	Tribal 638 provider-based facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.
09 - 10	Unassigned	N/A
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, state or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted living facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.
14	Group home	A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration).
15	Mobile unit	A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.
16 - 19	Unassigned	N/A

Place of Service Codes (continued)

Codes	Names	Descriptions
20	Urgent care facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.
21	Inpatient hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	Outpatient hospital	A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	Emergency room - hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory surgical center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Birthing center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of newborn infants.
26	Military treatment facility	A medical facility operated by one or more of the uniformed services. Military treatment facility (MTF) also refers to certain former U.S. public health service (USPHS) facilities now designated as uniformed service treatment facilities (USTF).
27 - 30	Unassigned	N/A
31	Skilled nursing facility	A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	Nursing facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick person, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
33	Custodial care facility	A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
35 - 40	Unassigned	N/A
41	Ambulance - land	A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
42	Ambulance - air or water	An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
43 - 48	Unassigned	N/A
49	Independent clinic	A location, not part of a hospital and not described by any other place of service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.
50	Federally qualified health center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51	Inpatient psychiatric facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.

Place of Service Codes (continued)

Codes	Names	Descriptions
52	Psychiatric facility -partial hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.
53	Community mental health center	A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services: screening for patients being considered for admission to state mental health facilities to determine the appropriateness of such admission; and consultation and education services.
54	Intermediate care facility/ mentally retarded	A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.
55	Residential substance abuse treatment facility	A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
56	Psychiatric residential treatment center	A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
57	Non-residential substance abuse treatment facility	A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.
58 - 59	Unassigned	N/A
60	Mass immunization center	A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.
61	Comprehensive inpatient rehabilitation facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy , occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
62	Comprehensive outpatient rehabilitation facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
63 - 64	Unassigned	N/A
65	End-stage renal disease treatment facility	A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
66 - 70	Unassigned	N/A
71	Public health clinic	A facility maintained by either state or local health departments that provides ambulatory primary medical care under the general direction of a physician.

Place of Service Codes (continued)

Codes	Names	Descriptions
72	Rural health clinic	A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.
73 - 80	Unassigned	N/A
81	Independent laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
82 - 98	Unassigned	N/A
99	Other place of service	Other place of service not identified above.

** Revised, effective October 1, 2005

Appendix D

Individual Adjustment Request Form

MONTANA MEDICAID/MHSP/CHIP
INDIVIDUAL ADJUSTMENT REQUEST

INSTRUCTIONS:

This form is for providers to correct a claim which has been paid at an incorrect amount or was paid with incorrect information. Complete all the fields in Section A with information about the paid claim from your statement. Complete ONLY the items in Section B which represent the incorrect information that needs changing. For help with this form, refer to the *Remittance Advices and Adjustments* chapter in your program manual or the *General Information For Providers II* manual, or call (800) 624-3958 (Montana Providers) or (406) 442-1837 (Helena and out-of-state providers).

A. COMPLETE ALL FIELDS USING THE PAYMENT STATEMENT (R.A.) FOR INFORMATION

1. PROVIDER NAME & ADDRESS

_____
Name

_____
Street or P.O. Box

_____
City **State** **Zip**

2. CLIENT NAME

_____

3. INTERNAL CONTROL NUMBER (ICN)

_____

4. PROVIDER NUMBER

_____

5. CLIENT ID NUMBER

_____

6. DATE OF PAYMENT _____

7. AMOUNT OF PAYMENT $ _____

B. COMPLETE ONLY THE ITEM(S) WHICH NEED TO BE CORRECTED

	DATE OF SERVICE OR LINE NUMBER	INFORMATION STATEMENT	CORRECTED INFORMATION
1. Units of Service			
2 Procedure Code/N.D.C./Revenue Code			
3. Dates of Service (D.O.S.)			
4. Billed Amount			
5. Personal Resource (Nursing Home)			
6. Insurance Credit Amount			
7. Net (Billed - TPL or Medicare Paid)			
8. Other/REMARKS (BE SPECIFIC)			

SIGNATURE: _____ **DATE:** _____

When the form is complete, attach a copy of the payment statement (RA) and a copy of the corrected claim (unless you bill EMC).

MAIL TO: ACS
P.O. Box 8000
Helena, MT 59604

Definitions and Acronyms

This section contains definitions, abbreviations, and acronyms used in this manual.

Administrative Rules of Montana (ARM)
The rules published by the executive departments and agencies of the state government.

Advanced Life Support Assessment
An assessment performed by an ALS crew as part of an emergency response that was necessary because the client's reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment. An ALS assessment does not necessarily result in a determination that the client requires an ALS level of service.

Advanced Life Support Intervention
A procedure that is, in accordance with state and local laws, beyond the scope of authority of an emergency medical technician-basic (EMT-Basic).

Advanced Life Support Personnel
An individual trained to the level of the emergency medical technician-intermediate (EMT-Intermediate) or paramedic.

Allowed Amount
The maximum amount paid to a provider for a health care service as determined by Medicaid or another payer. Other cost factors, (such as cost sharing, TPL, Medicare, or incurment) are often deducted from the allowed amount before final payment. Medicaid's allowed amount for each covered service is listed on the Department fee schedule.

Appropriate Facility
An institution generally equipped to provide the required hospital or skilled nursing care for the illness or injury involved. In the case of a hospital, it also means that a physician or physician specialist is available to provide the necessary care to treat the client's condition.

Assignment of Benefits
A voluntary decision by the client to have insurance benefits paid directly to the provider rather than to the client. The act requires the signing of a form for the purpose. The provider is not obligated to accept an assignment of benefits. However, the provider may require assignment in order to protect the provider's revenue.

Authorization
An official approval for action taken for, or on behalf of, a Medicaid client. This approval is only valid if the client is eligible on the date of service.

Basic Medicaid
Patients with Basic Medicaid have limited Medicaid services. See the *General Information For Providers* manual, *Appendix A: Medicaid Covered Services.*

Centers for Medicare and Medicaid Services (CMS)
Administers the Medicare program and oversees the state Medicaid programs. Formerly the Health Care Financing Administration (HCFA).

Children's Health Insurance Plan (CHIP)
This plan covers some children whose family incomes make them ineligible for Medicaid. DPHHS sponsors the program, which is administered by BlueCross BlueShield of Montana.

Clean Claim
A claim that can be processed without additional information from or action by the provider of the service.

Client
An individual enrolled in a Department medical assistance program.

Code of Federal Regulations (CFR)
Rules published by executive departments and agencies of the federal government.

Coinsurance
The client's financial responsibility for a medical bill as assigned by Medicaid or Medicare (usually a percentage). Medicaid coinsurance is a set dollar amount per visit, and Medicare coinsurance is usually 20% of the Medicare allowed amount.

Conversion Factor
A state specific dollar amount that converts relative values into an actual fee. This calculation allows each payer to adopt the RBRVS to its own economy.

Cost Sharing
The client's financial responsibility for a medical bill, usually in the form of a copayment (flat fee) or coinsurance (percentage of charges).

Crossovers
Claims for clients who have both Medicare and Medicaid. These claims may come electronically from Medicare or directly from the provider.

DPHHS, State Agency
The Montana Department of Public Health and Human Services (DPHHS or Department) is the designated state agency that administers the Medicaid program. The Department's legal authority is contained in Title 53, Chapter 6 MCA. At the federal level, the legal basis for the program is contained in Title XIX of the Social Security Act and Title 42 of the Code of Federal Regulations (CFR). The program is administered in accordance with the Administrative Rules of Montana (ARM), Title 37, Chapter 86.

Dual Eligibles
Clients who are covered by Medicare and Medicaid are often referred to as "dual eligibles."

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
This program provides Medicaid-covered children with comprehensive health screenings, diagnostic services, and treatment of health problems.

Emergency Response
Responding immediately at the BLS or ALS1 level of service to a 911 call or the equivalent in areas without a 911 call system.

Emergency Services
Those services which are required to evaluate and stabilize a medical condition manifesting itself by acute symptoms of sufficient severity (including pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or unborn child) in serious jeopardy, serious impairment to bodily function or serious dysfunction of any bodily organ or part. Transport must be from the scene or residence to the hospital.

EMT-Basic
An individual who is qualified in accordance with state and local laws as an EMT-Basic.

EMT-Intermediate
An individual who is qualified in accordance with state and local laws as an EMT-Intermediate.

EMT-Paramedic
An individual who is qualified in accordance with state and local laws as an EMT-Paramedic.

Fiscal Agent
ACS State Healthcare LLC is the fiscal agent for the State of Montana and processes claims at the Department's direction and in accordance with ARM 37.86 et seq.

Full Medicaid
Patients with Full Medicaid have a full scope of Medicaid benefits. See the *General Information For Providers* manual, *Appendix A: Medicaid Covered Services*.

Gross Adjustment
A lump sum debit or credit made to the provider that is not claim specific.

Immediate Response
The ambulance provider begins as quickly as possible to take the steps necessary to respond to the call.

Indian Health Service (IHS)
IHS provides health services to American Indians and Alaska Natives.

Individual Adjustment
A request for a correction to a specific paid claim.

Investigational
A non-covered item or service that researchers are studying to investigate how it affects health.

Kiosk
A "room" or area in the Montana Virtual Human Services Pavilion (VHSP) web site that contains information on the topic specified.

Loop Trip
A "loop trip" is performed when a client requires scheduled non-emergency service and is transported to the service and returned to the point of origin on the same day.

Mass Adjustment
Request for a correction to a group of claims meeting specific defined criteria.

Medicaid
A program that provides health care coverage to specific populations, especially low-income families with children, pregnant women, disabled people and the elderly. Medicaid is administered by state governments under broad federal guidelines.

Medicaid Eligibility and Payment System (MEPS)
A computer system by which providers may access a client's eligibility, demographic, and claim status history information via the internet.

Medically Necessary
A term describing a covered service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client. These conditions must be classified as one of the following: endanger life, cause suffering or pain, result in an illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There must be no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this definition, "course of treatment" may include mere observation or, when appropriate, no treatment at all.

Medicare
The federal health insurance program for certain aged or disabled clients.

Mental Health Services Plan (MHSP)
This plan is for individuals who have a serious emotional disturbance (SED) or a severe and disabling mental illness (SDMI), are ineligible for Medicaid, and have a family income that does not exceed an amount established by the Department.

PASSPORT To Health
A Medicaid managed care program where the client selects a primary care provider who manages the client's health care needs.

Prior Authorization (PA)
The approval process required before certain services or supplies are paid by Medicaid. Prior authorization must be obtained before providing the service or supply.

Private-pay
When a client chooses to pay for medical services out of his or her own pocket.

Provider or Provider of Service
An institution, agency, or person:

- Having a signed agreement with the Department to furnish medical care and goods and/or services to clients; and
- Eligible to receive payment from the Department.

Qualified Medicare Beneficiary (QMB)
QMB clients are clients for whom Medicaid pays their Medicare premiums and some or all of their Medicare coinsurance and deductibles.

Relative Value Scale (RVS)
A numerical scale designed to permit comparisons of appropriate prices for various services. The RVS is made up of the relative value units (RVUs) for all the objects in the class for which it is developed.

Relative Value Unit
The numerical value given to each service in a relative value scale.

Remittance Advice (RA)
The results of claims processing (including paid, denied, and pending claims) are listed on the RA.

Retroactive Eligibility
When a client is determined to be eligible for Medicaid effective prior to the current date.

Sanction
The penalty for noncompliance with laws, rules, and policies regarding Medicaid. A sanction may include withholding payment from a provider or terminating Medicaid enrollment.

Specified Low-Income Medicare Beneficiaries (SLMB)
For these clients, Medicaid pays the Medicare premium only. They are not eligible for other Medicaid benefits, and must pay their own Medicare coinsurance and deductibles.

Specialized Non-Emergency Transportation
Transport in a van designed for wheelchair or stretcher bound clients, which is operated by a provider with a class B public service commission license. This type of service does not require the same level of care as an ambulance, and clients using this service must have a disability or physical limitation that prevents them from using other forms of transportation to obtain medical services. Medicaid does not cover specialized non-emergency transports when another mode of transportation is appropriate and less costly.

Team Care
A utilization control program designed to educate clients on how to effectively use the Medicaid system. Team Care clients are managed

by a "team" consisting of a PASSPORT PCP, one pharmacy, the Nurse First Advice Line, and Montana Medicaid.

Third Party Liability (TPL)
Any entity that is, or may be, liable to pay all or part of the medical cost of care for a Medicaid, MHSP or CHIP client.

Trip Log
The form in *Appendix A* that providers can use for transport notification purposes.

Trip Report
The medical record documented during the ambulance run.

Timely Filing
Providers must submit clean claims (claims that can be processed without additional information or documentation from or action by the provider) to Medicaid within the latest of

- 12 months from whichever is later:
  - the date of service
  - the date retroactive eligibility or disability is determined
- 6 months from the date on the Medicare explanation of benefits approving the service
- 6 months from the date on an adjustment notice from a third party payor who has previously processed the claim for the same service, and the adjustment notice is dated after the periods described above.

Urgent Transport
When a client's health problem is not life threatening, but is serious enough to obtain help.

Usual and Customary
The fee that the provider most frequently charges the general public for a service or item.

Virtual Human Services Pavilion (VHSP)
This internet site contains a wealth of information about Human Services, Justice, Commerce, Labor & Industry, Education, voter registration, the Governor's Office, and Montana. http://vhsp.dphhs.state.mt.us

Index

A

B

C

D

E

F

G

H

I

K

L

M

N

O

P

Q

R

S

T

U

V

W